PREA Facility Audit Report: Final

Name of Facility: Pathway Campus II
Facility Type: Juvenile
Date Interim Report Submitted: 10/13/2024
Date Final Report Submitted: 12/23/2024

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	☑
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Latera M. Davis	**Date of Signature:** 12/23/2024

AUDITOR INFORMATION	
Auditor name:	Davis, Latera
Email:	laterad@yahoo.com
Start Date of On-Site Audit:	08/28/2024
End Date of On-Site Audit:	08/29/2024

FACILITY INFORMATION	
Facility name:	Pathway Campus II
Facility physical address:	145 Private Road 1107, Ozark, Alabama - 36360
Facility mailing address:	

Primary Contact

Name:	Adrian Patterson
Email Address:	apatterson@pathway-inc.com
Telephone Number:	(334) 445-1285

Superintendent/Director/Administrator	
Name:	Mark Sullivan
Email Address:	msullivan@pathway-inc.com
Telephone Number:	3344451285

Facility PREA Compliance Manager	
Name:	Adrian Petterson
Email Address:	apatterson@pathway-inc.com
Telephone Number:	(334) 465-0685

Facility Health Service Administrator On-Site	
Name:	Madelyn Cameron
Email Address:	mcameron@pathway-inc.com
Telephone Number:	3344451285

Facility Characteristics	
Designed facility capacity:	16
Current population of facility:	12
Average daily population for the past 12 months:	13
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Mens/boys

Which population(s) does the facility hold? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For definitions of "intersex" and "transgender," please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	12-18
Facility security levels/resident custody levels:	Medium Risk
Number of staff currently employed at the facility who may have contact with residents:	22
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Pathway, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	PO Box 311206, Enterprise, Alabama - 36331
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	Joe Peeples
Email Address:	jpeeples@pathway-inc.com

Telephone Number:	(334) 894-5591

Agency-Wide PREA Coordinator Information			
Name:	Kimberly Fail	**Email Address:**	kfail@pathway-inc.com

Facility AUDIT FINDINGS

Summary of Audit Findings

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

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
1	• 115.311 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
Number of standards met:	
42	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION	
GENERAL AUDIT INFORMATION	
On-site Audit Dates	
1. Start date of the onsite portion of the audit:	2024-08-28
2. End date of the onsite portion of the audit:	2024-08-29
Outreach	
10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Alabama Division of Youth Services National Sexual Assault Line
AUDITED FACILITY INFORMATION	
14. Designated facility capacity:	15
15. Average daily population for the past 12 months:	15
16. Number of inmate/resident/detainee housing units:	2
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
18. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	15
19. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
20. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	0
21. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
22. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
23. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
24. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	0

25. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
27. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	2
28. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
29. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all residents in the facility. The facility houses all male residents. The facility was able to utilize data from the risk assessment to identity any targeted populations.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
30. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	19
31. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0

32. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
33. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all staff by title and shift.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

34. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	8
35. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☐ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☐ Gender ☐ Other ☐ None

36. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	As an auditor, the process of selecting residents for interviews is designed to ensure a fair and unbiased representation of the population. Typically, we use a random selection method, often through a random number generator or a similar unbiased tool, to choose residents from the list. However, due to the limited number of residents at the facility that were onsite during the audit, the auditor selected all those available while onsite.
37. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	(●) Yes ( ) No
38. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	The auditor oversampled the minimum number of resident interviews due to the limited number of targeted residents identified.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	2

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

40. Enter the total number of interviews conducted with inmates/residents/ detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
40. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

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

41. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	0
41. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

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

42. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
42. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

42. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
43. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0

43. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

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

44. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
44. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

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

45. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
45. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

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

46. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
46. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

46. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
47. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0

47. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

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

48. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	2
49. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
49. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

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

50. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
51. Enter the total number of RANDOM STAFF who were interviewed:	8

52. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
53. Were you able to conduct the minimum number of RANDOM STAFF interviews?	○ Yes ◉ No
53. Select the reason(s) why you were unable to conduct the minimum number of RANDOM STAFF interviews: (select all that apply)	☐ Too many staff declined to participate in interviews. ☐ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☑ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other
54. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	The auditor interviewed all of the random staff who were scheduled to work during all shifts during the onsite audit process.

Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	23
56. Were you able to interview the Agency Head?	(●) Yes ( ) No
57. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
58. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
59. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

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

	☑ Other
If "Other," provide additional specialized staff roles interviewed:	Interviewed DYS Advocate who reviews state DYS grievances.
61. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
62. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
63. Provide any additional comments regarding selecting or interviewing specialized staff.	The audited site is a small facility. Several staff maintain dual roles throughout the facility.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

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

64. Did you have access to all areas of the facility?	◉ Yes ○ No

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

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

Documentation Sampling

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

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

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

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

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

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

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

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

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

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

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

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

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

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

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

Sexual Harassment Investigation Outcomes

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

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

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

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

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

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

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

79. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
80. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
81. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
82. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
83. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
84. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

85. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
86. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	3
87. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	◉ Yes ○ No ○ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
88. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	3
89. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
90. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
91. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
92. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
93. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
94. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	All allegations of sexual harassment were reviewed. There were no reported allegations of sexual abuse.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

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

Non-certified Support Staff	
96. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

AUDITING ARRANGEMENTS AND COMPENSATION	
97. Who paid you to conduct this audit?	◉ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Organizational Chart 2. Interviews: a. PREA Coordinator b. PREA Compliance Manager Findings (By Provision):

	115.311 (a). An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual, “This manual provides guidelines and procedures to reduce the risk of sexual abuse and sexual harassment at all Pathway, Inc owned and operated facilities. It is also a written plan to coordinate actions taken in response to an incident of sexual abuse, among staff, residents, volunteers, contractors, and facility leadership. Pathway is committed to a zero-tolerance standard for sexual abuse and sexual harassment either by staff or by other residents” (p. 1). The policy provides a process for which the facility will implement the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual, further defines sexual abuse: · Sexual Abuse: · Sexual abuse of a client/resident by a staff member, contractor, or volunteer when the victim does not consent and is coerced into such acts by overt or implied threats of violence or is unable to consent or refuse. These include any of the following actions: · Contact between the penis and the vulva or the penis and the anus, including penetration, however slight; · Contact between the mouth and the penis, vulva, or anus; · Contact between the mouth and any body part when the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire; · Penetration of the anal or genital opening, however slight, by a hand, finger, or object, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire; · Any intentional contact, either directly or through the clothing, with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire; · Any attempt, threat, or request by a staff member, contractor, or volunteer to

	engage in the activities described above in letters a through e; · Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of a resident, and · Voyeurism by a staff member, contractor, or volunteer that involves an invasion of a resident's privacy by staff for reasons unrelated to official duties such as: · Peering at a resident who is using a toilet in the residence to perform bodily functions; · Requiring a client/resident to expose his buttocks, genitals, or breasts; or taking images of all or part of a client's/resident's naked body or of a client/resident performing bodily functions, regardless of what the staff member does with the images afterwards. · Sexual abuse of a client/resident by another client/resident includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse: · Contact between the penis and the vulva or the penis and the anus, including penetration, however slight; · Contact between the mouth and the penis, vulva, or anus; · Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument; and · Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation. · Sexual Abuse Advocate - An individual specifically trained to offer advocacy, support, crisis intervention, information, and referrals to a victim of sexual abuse. · Sexual Abuse Response Team (SART) - A team of staff which may include Pathway's Program Director, Therapists, Senior Shift Leader Supervisors, and auxiliary staff. The team is managed by the Program Director. The purpose of the team is to ensure a holistic approach to investigations and support for victims. · Sexual Abuse Forensic Examination - A process performed by a sexual abuse nurse examiner (SANE) during which the medical forensic history and evidence is obtained from the client. The SANE must offer the resident information on sexually transmitted infections, and other non-acute medical concerns. · Sexual Coercion - Compelling or inducing another person to engage in sexual abuse by deceit, threats, force, or intimidation for personal favors. · Sexual Harassment -

	· Client/Resident to Client/Resident sexual harassment includes repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one client/resident or clients/residents directed towards another. · Staff to Client/Resident sexual harassment includes repeated verbal comments or gestures of a sexual nature to a client/resident or clients/residents by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures. · Staff Sexual Misconduct - The following acts when performed by agency staff, contractors, or volunteers when directed at a client/resident for the purpose of gratifying the sexual desire(s) of any person, encouraging a client/resident to engage in staff sexual misconduct, or that have sexual undertones: Making any of the following: Comments about a client's/resident's body, looks, or conduct intended to arouse or gratify the sexual desire of any person, or to abuse, humiliate, harass, or degrade any person. · Sexually oriented statements or gestures in the presence of a client/resident; or · Demeaning statements based on gender or sexual orientation in the presence of a client/resident. · Giving or accepting personal letters, pictures, phone calls, or contact information with a client/resident, or his/her family, without express authorization of the parent or legal guardian. · Engaging in discussions about personal information with a client/resident, or his/her family, or to encourage a client/resident to engage in communication or conduct with a staff person that would constitute staff sexual misconduct. · Dealing, offering, receiving, or giving favors or attention to a client/resident for purposes of grooming, bribing, or otherwise seeking to engage a client/resident in activities prohibited by policy. · Discussing or preventing clients/residents, staff, contract workers, and/or volunteers from: · Making good faith reports of staff sexual misconduct; or · Providing, in good faith, information regarding sexual misconduct where a client/resident is the alleged victim, including such examples as, making threats, bribes, or acts of coercion toward a resident, staff, contract worker, or volunteer. This does not include short-term temporary delays in reporting necessary to ensure safety/security in the facility or instances where the staff, contract worker, or

	volunteer would not reasonably have known under the circumstances that he/she was in violation of this policy. · Attempting to perform acts prohibited by this policy. · Aiding or abetting another person to perform acts prohibited by this policy, including intentionally failing to report knowledge of another staff, contract worker, or volunteer engaging in staff sexual misconduct or other acts prohibited by this policy (pp 2-5). · Furthermore, the policy includes sanctions for those found to have participated in prohibited behaviors: · DISCIPLINE: It is the policy of Pathway that all staff will be subject to disciplinary sanctions up to and including termination for violating the sexual harassment and sexual abuse policies. · Staff that have engaged in sexual abuse, sexual coercion, or sexual harassment will be terminated from Pathway. · Disciplinary sanctions for violating the sexual abuse or sexual harassment policy but not for actually engaging in sexual abuse will be based on the following: · The nature and circumstances of the acts committed. · The staff member's disciplinary history. · The sanctions imposed for similar offenses by other staff with similar histories. · All staff, contractor, and volunteer terminations or resignations resulting from criminal sexual abuse will be referred to law enforcement. · All contractors and volunteers who violate Pathway's sexual abuse and/or sexual harassment policies will be prohibited from further contact with clients/ residents. Where applicable, law enforcement and licensing agencies will be notified. Pathway will take appropriate remedial measures and consider whether to prohibit further contact with clients/residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. · Clients/residents will be subject to disciplinary sanctions through a formal disciplinary process following; · An administrative finding that the client/resident engaged in client/resident - on - client/resident sexual abuse or sexual harassment. · Following a criminal finding of guilt for client/resident - on - client/resident sexual abuse or sexual harassment. · Sexual abuse/assault/harassment/coercion are serious misconduct violations for clients/residents in Pathway's program. Any form of such sexual behavior will

result in termination from the program.

· In the event a disciplinary sanction for resident-on-resident sexual abuse results in the isolation of a resident, Pathway will follow the protocol for isolation (see Section IV, number 13).

· Pathway offers therapy, counseling and other interventions designed to address and correct the underlying reasons or motivations for abuse, in the event the alleged abuser remains in the program. Pathway will consider whether to require the offending client/resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general programming or education is not conditional on participation in such interventions.

· A client/resident's report of sexual abuse made in good faith and based on reasonable belief will not be disciplined for falsely reporting an incident, even if the investigation does not establish evidence sufficient to substantiate the allegation.

· Pathway will discipline a client/resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

· Pathway prohibits all sexual activity between clients/residents. As such, Pathway will discipline residents for such activity. Pathway deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Corrective Actions:

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

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

115.311 (b). An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

Compliance Determination:

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

· As reported in the PAQ, the facility employs an upper level, agency wide PREA coordinator, Kimberly Fail. According to the agency organizational chart, the agency PREA coordinator reports to the Chief Executive Officer. It was further reported that the PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

· The agency/facility has PREA policies which ensure the sexual safety of facility residents and staff. The policy includes zero-tolerance philosophy from the

agency central office through the front-line staff in its facilities. The agency/facility PREA coordinator has direct access to the head of the agency and regular communication with the senior leadership team.

· Agency Organization Chart: the agency organization chart demonstrates that the PREA coordinator is an upper-level staff member.

Interviews:

PREA Coordinator: The interviewed staff reported that they have time to manage their PREA-related responsibilities. I am able to prioritize all PREA incident reviews to ensure that the PREA Compliance Managers followed our PREA policies and procedures, clients' needs were adequately met, and appropriate consequences were enforced for any offenders.

There are four Compliance Managers within Pathway, Inc, one of which works onsite in Baldwin and I interact with her often (and directly supervise her). The other three I interact with a minimum of monthly during integrity review committee meetings. They all have my cell number and are able to reach me with any concerns relating to PREA policies, procedures, practices, or incidents.

If issues are identified, I would address the issue with the Compliance Managers directly and ensure an immediate correction is enforced. If disciplinary action is warranted, I would carry this out as well. I do ensure all Compliance Managers have adequate knowledge of the PREA standards and Pathway Policies to carry out their duties. If this non-compliance occurred at another campus, I would work in person at that site to ensure corrective action is implemented.

115.311 (c): Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

Compliance Determination:

· According to the PAQ, the facility designated PREA compliance manager. The Director of Programs at each campus serves as the PREA Compliance Manager. It was further reported that the PREA Compliance Manager has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. The position of the PREA Compliance Manager in the agency's organizational structure: Baldwin Director of Programs. The person to whom the PREA Compliance Manager reports: Program Director.

· Organizational Chart: the agency organization chart demonstrates that the PREA compliance manager is a facility staff.

Interviews:

PREA Compliance Manager: The interviewed staff reported that they have enough time to manage all of the PREA-related responsibilities. The PREA standards are coordinated by continued training, policy review and following up, and monthly

	meetings. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard. The audited facility significantly surpasses the requirements of PREA Standard 115.311. It demonstrates a robust and unwavering commitment to maintaining a zero-tolerance policy for sexual abuse and sexual harassment. The facility has implemented comprehensive policies and procedures that go above and beyond the minimum standards. These include: Extensive Training Programs: Staff receive in-depth, ongoing training that covers all aspects of PREA compliance, including advanced techniques for recognizing and responding to signs of sexual abuse and harassment. • Proactive Prevention Measures: The facility has instituted proactive measures that prevent incidents before they occur, including detailed risk assessments, frequent inspections, and rigorous screening processes. • Strong Support Systems: There are well-established support systems for residents, which include immediate access to confidential reporting mechanisms, comprehensive counseling services, and dedicated victim support staff. • Thorough Policies: The facility has a thorough and comprehensive policy that addresses all requirements of the standards and provisions. • Culture of Accountability: A culture of accountability is fostered at all levels, with clear consequences for any violations. This culture is reinforced by regular audits, transparent reporting, and a commitment to continuous improvement. These efforts collectively create an environment where the safety and dignity of residents are prioritized, and any form of sexual abuse or harassment is unequivocally condemned and addressed.

115.312	**Contracting with other entities for the confinement of residents**

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.):

a. Pre-Audit Questionnaire (PAQ)

2. Interviews:

a. Agency contract administer-1

Findings (By Provision):

115.312 (a). A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.

Compliance Determination:

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

· The Pre-Audit Questionnaire (PAQ) indicated that the agency has not entered into or renewed contracts for the confinement of residents on or after August 20, 2012, or since the last PREA audit. However, after further review it is determined that the site is the contracted site for the Alabama Department of Youth Services. The site does not have a subcontract for the confinement of residents.

Corrective Action:

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

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

115.312 (b). Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

Compliance Determinations:

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

· The Pre-Audit Questionnaire (PAQ) indicated that the agency has entered into or renewed contracts for the confinement of residents on or after August 20, 2012, or since the last PREA audit. However, after further review it is determined that the site is the contracted site for the Alabama Department of Youth Services. The site does not have a subcontract for the confinement of residents.

	Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.313	**Supervision and monitoring**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.): a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual Staffing c. Supervisor monitoring log (12 months) d. Staffing Plan 2. Interviews: a. Superintendent (Facility Director) b. PREA Coordinator c. Intermediate or higher-level staff (2) 3. Corrective Action: a. Unannounced Rounds (September – November, 2024) b. Training (Unannounced Rounds) 4. Site Review Findings (By Provision):

	115.313 (a). The agency shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire that the agency ensures that each facility it operates develops, implements, and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents: 16. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents on which the staffing plan was predicated: 16. · Documented annual staffing plan provides a staffing plan that provides for adequate levels of staffing (2024 Annual Staffing Plan). · The facility has cameras to supplement supervision of residents. They are in and out of the facility to help eliminate blind spots and to assist in monitoring residents. Site Review Staffing Patterns and Shifts: The auditor observed staffing patterns during all shifts. The facility operates on two shifts across three buildings: one school and two housing units. The site houses, programs, and provides educational services for each dormitory separately. One dorm housed seven residents, while the other housed eight residents. The maximum number of rooms on each dorm is eight. Day Shift: During the day, the auditor observed appropriate staffing levels in the housing units, with a minimum of one staff member present at all times, supplemented by a rover. A mental health professional was also available during the day, with an office located within the housing unit. All staff members are trained uniformly and serve as direct care staff. Programming occurs within the housing units. In the recreation yard, there was at least one staff member for every seven residents in one dorm and one staff member for every eight residents in the other dorm, along with two rovers present at all times during day shifts. In the education setting, there was one direct care staff and one teacher for every seven to eight residents. The site has been operational for one year, with no identified areas where sexual abuse is more likely to occur, based on prior incidents or the staffing plan. Evening Shift: During the evening shift, residents were supervised by one staff member and one rover per dorm. Direct supervision and line-of-sight monitoring were maintained in each housing area.

	Security Measures: The auditor observed multiple cameras in the housing units and education areas. Cameras were strategically placed to cover all potential blind spots, including entrances, exits, and hallways near bathrooms. Residents occupy single sleeping spaces without doors, ensuring continuous visibility. The dorms are designed in a small T-shape, facilitating constant monitoring by staff. The facility layout and camera system also allow leadership to remotely monitor the site. Audit Observations and Resident Feedback: No staffing concerns were identified during the onsite audit. The auditor engaged in informal conversations with on-site staff, who confirmed maintaining a 1:8 staff-to-resident ratio. Residents reported feeling safe, consistently supervised, and never left unsupervised. Interviews: PREA Compliance Manager: When assessing adequate staffing levels and the need for video monitoring to see what is needed and best practice expectations. There are no judicial findings or federal investigative agencies. There are no findings of inadequacy from internal or external oversight bodies. If so, DHR would make recommendation and we would respond. We would look at all of the above areas. Director: The staffing plans are developed monthly to ensure proper planning for coverage and supervision of clients. Additionally, there are cameras. The staffing plan is documented. We maintain a minimum of 1:8 ratio. Night shift has floaters that periodically check in on clients and staff to prevent sexual abuse. Usually at least one floater. Video monitoring is a part of the plan. There are cameras across the facility with the exception of bathrooms. Clients are not allowed to enter the bathroom with other clients unless a staff member is present to monitor. The staffing plan is documented and reviewed monthly. When assessing staffing levels, the below are addressed: Generally accepted detention practices: Exceed minimum standards. Judicial Findings: None. If so, would be immediately corrected. Inadequacy from federal investigations: None. If so, would be immediately corrected. Inadequacy from internal or external oversight bodies: None. If so, would be immediately corrected. All components of the facility’s physical plant (including “blind spots” or areas where staff or residents may be isolated); All areas covered with cameras we monitor for blind spots. Composition of resident population: Administration makes every effort to deny residents who are not appropriate for the program due to sexually inappropriate behaviors. Vulnerability assessments are completed at intake.

	The number and placement of supervisory staff: considered in the staffing plan addressing when residents are most active and on night shift. Additional staff are provided during the day hours. Institution programs: Staff are present during all scheduled activities and programming. Any applicable state or local laws, regulations, or standards: DYS standards 1:8 and 1:10. The prevalence of substantiated and unsubstantiated incidents of sexual abuse: As a part of the PREA incident review, Pathways monitors for prevalence of incidents and provides additional staffing as needed to prevent further incidents. Compliance with the staffing plan is checked by making sure that cameras are checked verifying that they work properly and the cover the area needed. Staffing is monitored daily to ensure the appropriate number of staff are on shift for the day/ night. Supervisors' complete random checks of staff and document theses, which are reviewed by administrative staff as well. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.313 (b). The agency shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According to the PAQ the facility has not deviated from the staffing plan. The facility operates a staffing plan that meets the PREA ratio standards. The current staffing ratios for the facility is 2:8 through the waking hours and 1:8 during sleeping hours. Interviews: Director– There have been no situations that have hindered the facility from meeting the staffing pattern. IF there are multiple call in on a shift that have the potential to effect the staffing plan, Pathway has a procedure that requires administrative staff to come in to cover the shift to ensure compliance. Instances of noncompliance must be documented and explained. Corrective Actions:

	· N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.313 (c). Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: According to the PAQ, the facility exceeds staffing ratios by maintaining the staffing ratios of minimum 2:8 during resident waking hours and 1:8 during resident sleeping hours. As reported, the facility has not deviated from the staff ratios of 2:8 during waking hours and 1:8 during resident sleeping hours. The current 2:8 and 1:16 ratios exceed the staffing requirements. In the past 12 months, the number of times the facility deviated from the staffing ratios of 1:8 security staff during resident waking hours: 0. In the past 12 months, the number of times the facility deviated from the staffing ratios of 1:16 during resident sleeping hours: 0. Interviews: Director: The facility is required to meet DYS standards of 1:8 day and 1:10 night. Pathway has hired more than the required number of staff to meet the ratio. Staffing is regularly monitored. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.313 (d). Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to: (1) The staffing plan established pursuant to paragraph (a) of this section; (2) Prevailing staffing patterns; (3) The facility's deployment of video monitoring systems and other monitoring technologies; and (3) The resources the facility has available to commit to ensure adherence to the staffing plan. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: · As reported in the PAQ, at least once a year the facility, in collaboration with the agency's PREA coordinator; reviews the staffing plan to see whether adjustments are needed to: o The staffing plan; o Prevailing staffing patterns o The deployment of monitoring technology; or o The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan. · Annual Review of staffing plan (2024). The staffing plan addresses all of the above-mentioned areas. Interviews: PREA Coordinator – The interviewed PREA Coordinator reported that we meet weekly at the Baldwin campus and Monthly with Pathway, Inc staff to ensure that the staffing plan is adequate. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.313 (e). Each secure facility shall implement a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has a policy and practice in place where intermediate or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. It was further reported that the unannounced rounds covered all shifts. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway supervisors conduct unannounced rounds

during both day and night shift to ensure compliance with these policies and procedures. Staff shall not notify other staff members of the unannounced rounds. If these notifications are made, the staff member making the notification will receive disciplinary action, up to and including termination" (p. 6).

· Supervision Monitoring Logs: The supervision monitoring logs provided a 10-month process of staff monitoring visits. The logs documented monitoring during the day and evening hours.

Interviews:

Intermediate or Higher-Level Staff- The interviewed staff reported that unnanounced rounds are conducted to ensure that residents are on schedule and doing what they are supposed to do. When the rounds are conducted staff do not know when we are coming around. We will come around at random times throughout the day and the night. The rounds are done by walking the facility making sure the youth are secure and things are done as they are supposed to be done. The staff further reported that while they have been conducting the rounds, they have not documented them.

Corrective Actions:

· The supervision monitoring logs should represent monitoring to include late night and early morning hours. The facility shall develop a corrective action plan and show proof of conducting monitoring over a three-month period during the late night/early morning as well as day hours. The corrective action plan was developed and submitted on 8/19/2024.

· Executive Director will provide training for all supervisory staff members regarding the reasons for facilitating unannounced rounds, the expectations for completing unannounced rounds, and how to appropriately document the completed unannounced rounds.

· Due date: 11/15/2024.

Corrective Action Implemented:

· Training: Training was conducted on 10/23 and 10/24/2024 on how to conduct unannounced rounds.

· Unannounced Rounds Logs: The facility provided documentation of unannounced rounds for the months of September through November, 2024. While the rounds were conducted throughout the day, the facility leadership shall continue to monitor how the notes are documented and clearly indicating AM or PM.

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

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility,

	facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility has corrective action to address unannounced rounds. The corrective actions items were completed and follow-up review, confirmed that the items of concern are compliant with the requirements of the standard. The facility is in compliance with the standard.

115.315	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Guidelines for Resident Strip Searches Training d. Strip Searches Training Log (14) Dated July 22, 2024 e. Searches Training Signed Sheet (20) 2. Interviews: a. Random sample of staff (8) b. Random sample of residents (10) 3. Corrective Action: a. Training (Opposite Gender Announcement) Findings (By Provision): 115.315 (a). The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility does not conduct cross-gender strip or cross gender visual body cavity searches of residents. The facility reported that staff receive the following training: Guidance in Cross Gender and Transgender Pat Searches. In the past 12 months, the number of cross-gender strip or cross-gender visual body cavity searches of residents: 0. In the past 12 months, number of cross-gender strip or cross-gender visual body cavity searches of residents that did not involve exigent circumstances or were performed by non-medical staff: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual, states that “Pathway will not conduct cross-gender strip searches or cross-gender visual body cavity searches, except when performed by medical practitioners. All cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches shall be well documented and justified” (p. 7). · The facility leadership reported that the site does not conduct any type of pat-down search. Site Review: · Search Observations: o The auditor did not observe any searches being conducted during the site review. · Staff Practices: o In informal conversations, staff confirmed that they are not permitted to conduct cross-gender strip or pat-down searches. They emphasized that they do not place their hands on residents, and any searches conducted during intake are performed by staff of the same gender as the resident. · Resident Feedback: o Residents reported that they have never experienced a search by female staff. They also stated that no staff member has ever conducted a strip or pat-down search on them. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.315 (b). The agency shall not conduct cross-gender pat-down searches except in exigent circumstances. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that it does not permit cross-gender pat-down searches of residents, absent exigent circumstances. In the past 12 months, the number of cross-gender pat-down searches of residents: 0. In the past 12 months, the number of cross-gender pat-down searches of residents that did not involve exigent circumstance(s): 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway will not conduct cross-gender strip searches or cross-gender visual body cavity searches, except when performed by medical practitioners. All cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches shall be well documented and justified. Pathway does not authorize or permit pat searches on any client/resident. At no time will Pathway allow body visual cavity search to be conducted on a client/ resident, except when performed by medical practitioners” (p. 7). · The facility does not permit cross-gender part-down searches and has a policy against this practice. This facility is males only. Interviews: Random Sample of Staff: the interviewed staff reported that they do not conduct any cross-gender pat-down searches. Residents(s) in custody Interview Questionnaire: All of the interviewed residents reported that they have never been pat down searched by opposite gender staff. Corrective Actions: · N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.315 (c). The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their response to the PAQ that the facility policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches shall be well

documented and justified” (p. 7).

Corrective Actions:

· N/A. There are no corrective actions.

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

115.315 (d). The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

Compliance Determination:

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

· As indicated in the PAQ, the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks, along with policies and procedures that advise staff.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway shall implement policies and procedures that enable clients/residents to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks. All staff, regardless of gender, must announce their intention to enter a resident's room/bathroom area during times that the resident is likely to be dressing or undressing. It is not necessary for staff to announce their presence when security checks are being made while residents are sleeping” (pp. 6-7).

Site Review:

· Observation of Areas Where Residents May Be Undressed:

o The auditor inspected all areas where residents might be in a state of undress, such as while showering, using the toilet, or changing clothes. The only location where this occurs is within the housing area, which has a large bathroom containing four shower stalls, three toilet stalls, four sinks, and a laundry area.

	o Each shower stall has a door and an open space for residents to change, with a separate shower and curtain within the stall. Residents are not allowed to change in their rooms as the rooms do not have doors. o The toilet area is enclosed with stall doors, ensuring residents do not use the toilet in an open area. · Cross-Gender Observation and Privacy: o The auditor assessed whether non-medical staff of the opposite gender could view residents in a state of undress, including from different angles or via mirrors. The facility's design ensures that staff do not have a direct line of sight into areas where residents undress or use the toilet. Mirrors are only present above the sinks in the bathroom. o The auditor also reviewed the electronic surveillance monitoring areas and confirmed that management staff do not have the ability to observe residents in restroom areas where they could be undressed. No mirrors are used in the housing area for surveillance purposes, and the facility does not employ any software or physical mechanisms (e.g., pixelation, post its, tape) to obscure cross-gender viewing. Observation of the camera system occurred in the Directors Office. · Staff and Resident Feedback: o In informal conversations, direct care staff reported that residents shower and change only in the bathroom, with no more than two residents allowed in the bathroom at a time, and they cannot use adjacent stalls. Staff emphasized that residents must remain fully dressed at all times. o Residents reported that staff never see them in a state of undress and that they are expected to be fully clothed at all times. They noted that it is strictly prohibited to walk around without a shirt. · Opposite Gender Announcements: o During the site review, the auditor observed that staff did not make an opposite-gender announcement when entering the housing area or restroom. However, it was noted that opposite-gender staff did not enter the restroom area when residents were present, and residents had to request permission to enter the restroom. o The auditor also observed that opposite-gender staff were already in the housing area before the auditor's entrance. o In informal conversations, staff reported that opposite-gender announcements are consistently made. Residents confirmed this, stating that either the opposite-gender staff or a male staff member announces when an opposite-gender staff enters the building. Residents also noted that opposite-gender staff typically avoid entering the restroom area. Interviews:

Random Sample of Staff: All of the interviewed staff reported that residents(s) in custody can dress, shower, and use the toilet without being viewed by staff of the opposite gender and that female presence on housing units is announced. The interviewed staff reported that they make an announcement when they enter the housing unit. The staff further reported that the female staff do not go into the restrooms when the residents are in the restroom.

Residents(s) in custody Interview Questionnaire: All but one of the interviewed residents reported that female staff announce themselves when entering the housing area. One of the residents reported that the staff just started making the announcement. All of the residents reported that they are never naked in full view of the opposite gender staff. The residents further reported that they are not naked in front of any staff. They are expected to change in the shower area.

Corrective Actions:

· The facility shall retrain staff on conducting opposite gender announcements and provide an update to the auditor showing the staff that was trained, the date of training, and areas of discussion.

Due Date: 11/1/2024

Corrective Action Taken: Training was conducted with staff on 10/23 and 10/24/2024 on Opposite Gender Announcements. No further action is needed.

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

115.315 (e.) The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

Compliance Determination:

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

· Per the PAQ, the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. There were no reported searches that were conducted in the last 12 months.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway's staff shall not search or physically examine any client/resident for the sole purpose of determining the client's/ resident's genital status. If the client's/resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical

	records, or if necessary, by learning that information as part of a broader medical examination by a medical practitioner." (p. 7). Interviews: Random Sample of Staff: Interviews were conducted with all staff working during the audit period. All of the interviewed staff reported that they are not allowed to search or physically examine a transgender or intersex individual in custody for the purpose of determining the individual in custody's genital status. Corrective Actions: · N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.315 (f). The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility trained one hundred percent of security-staff on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs as such searches are prohibited. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "there should be both male and female staff on duty at all times. No cross-gender pat down searches, or visual body cavity searches should ever occur unless in the rarest of exigent circumstances and only after contacting the Detention" (p. 12). · Guidelines for Resident Strip Searches Training: the training overview provides an overview of the expectation on how strips searches are conducted. · Strips Searches Training Log: Fourteen staff completed in-service training on July 22, 2024. While the staff are trained the agency prohibits strip searches or cross gender pat down searches. However upon further review the auditor identified at least 20 current staff who completed searches training. Interviews Random Sample of Staff: All staff working during the audit period were interviewed. The staff reported receiving training; however cross gender pat down searches is not allowed. The staff reported that the training also included searching a

	transgender resident. Corrective Actions: · N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility has corrective action to conduct retraining with staff on opposite gender announcements. The corrective actions were completed as of 10/24/2024 and follow-up review, confirmed that staff were trained on their responsibilities addressing opposite gender announcements. The facility is in compliance with the standard. Following the corrective action period, the requested documentation was provided and assessed to be in alignment with the PREA standard. Upon final review, the facility has been determined to be compliant.

115.316	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Pre-Audit Questionnaire (PAQ) a. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual b. Contract for Interpreter Services (Visual Language Professionals LLC) 2. Interviews: a. Random sample of staff (8) Findings (By Provision): 115.316 (a). The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those

	who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans with Disabilities Act, 28 CFR 35.164. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility, does not have established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment. It was further reported that a resident with a disability would not be appropriate for the program; therefore, denied admission. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: Pathway is an intense, cognitively demanding treatment program. Pathway cannot accommodate clients/residents who are deaf, have profound intellectual disabilities, who are blind, or who are not English speaking in its non-contract treatment program. Pathway does not allow the use of resident interpreters, resident readers, or other types of resident assistants, except in limited circumstances were an extended delay in obtaining an effective interpreter could compromise the client’s/resident’s safety, the performance of first-response duties, or the investigation of the client’s/resident’s allegations. In circumstances in which client/resident assistants are used, the reason for such use is well documented (pp. 7-8) · The agency also provides written materials in formats or through methods that ensure effective communication with residents/residents, who have intellectual disabilities, limited reading skills or who are blind or have low vision. The site reported that they are not equipped to access residents with physical disabilities or who are blind or have low vision. However, if there was an intellectual disability to site would coordinate with the public school for additional resources. The site director is also a special education instructor and reported that the school would assist as needed with additional resources. · Contract for Interpreter Services (Visual Language Professionals): The site

	utilizes the DYS contract for interpreter services. The services allow for 24/7 access to an interpreter for multiple languages along with the ability for the site to request documentation interpreter services. The site stated that they have not had to utilize any type of interpreter services since opening. · Site Review · While the facility did not have any residents who were limited English Speaking, the auditor was able to test securing interpretation services on-demand. o The auditor contacted the language line and spoke to the staff on the process to access on demand languages. The staff table walked the auditor through the process so the site would not be charged for the use of services. We went through providing the pin and the prompts for various languages. There are nine languages available for on-demand services and any other language would have to be requested. · While the residents would not have to self-identify the facility would have to enter a pin number to access the contract on-demand services. The residents at the facility do not have access to a phone at any given time, therefore accessing such services would be limited to staff request for services. · The interpreter services are available 24/7 with staff assistance to access the line. · As described by the Clinician, in coordination with the Director the language line services would be accessed and the use of the interpreter would occur in a closed door in the Clinician Office. Additionally: · During informal and formal conversation with the mental health staff who conduct intake it was reported that if interpreter services were needed, they would coordinate with the facility director to access the services. As of the facility opening, they have not had to access interpreter services. Interviews: Agency Head-The interviewed agency head reported that for the Baldwin campus, no. These clients are excluded by our admission criteria due to posing a safety risk for themselves. For the IDI campus and Medium Risk Campuses, yes. We have contracted services to provide interpreters to assist with their understanding and educate them regarding all PREA related procedures. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

	115.316 (b). The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway is an intense, cognitively demanding treatment program. Pathway cannot accommodate clients/residents who are deaf, have profound intellectual disabilities, who are blind, or who are not English speaking in its non-contract treatment program (p. 7). · In the event interpreter services are needed, the program will utilize services attained by Alabama DYS (Visual Language Professionals LLC). Interviews: Residents (with disabilities or who are limited English proficient) – There were no residents, during the onsite audit that identified as disabled or limited English proficient. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.316 (c). The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility prohibits the use of resident interpreters,

	readers, or other types of resident assistance and there were zero instances where resident interpreters, readers, or other types of resident assistants have been used. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. In the past 12 months, the number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway does not allow the use of resident interpreters, resident readers, or other types of resident assistants, except in limited circumstances were an extended delay in obtaining an effective interpreter could compromise the client's/resident's safety, the performance of first-response duties, or the investigation of the client's/resident's allegations" (p. 8)". Interviews: Random Sample of Staff: The interviewed staff reported that they would not allow for resident interpreters. If an interpreter were needed, they would seek assistance from a supervisor. The staff reported that they had never seen an instance where residents served as interpreters for each other. Residents (with disabilities or who are limited English proficient) - There were no residents, during the onsite audit that identified as disabled or limited English proficient. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.317	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-audit Questionnaire (PAQ) b. The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. PREA Employment Questionnaire- pending d. Background Checks i. Staff (5) ii. Child Abuse Registry (20) 2. Interviews: a. Administrative (Human Resources) Staff 3. Corrective Action: a. Employee Background Checks (15) b. 5 Year Background Check (3) Findings (By Provision): 115.317 (a). The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who: 1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution.

2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, of if the victim did not consent or was unable to consent or refuse; or

3. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2) of this section.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway will not employ any applicant, contractor, or volunteer who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; 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 the activity described above. Pathway will consider all incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor or volunteer, who may have contact with clients/residents." (p. 6).

· New Hire Criminal Background Checks (5)

Corrective Actions:

· Background Check: Prior to the conclusion of the interim report the auditor did not receive all of the requested documents on staff. The facility shall provide a copy of the pending documentations.

Corrective Action Taken: Additional Background Checks were provided for 15 staff; showing the agency's practice of completing background checks on new hires.

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

115.316 (b). The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

Compliance Determination:

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

· As reported in the PAQ, the facility, has a policy that requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with the residents.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway will consider all incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the

services of any contractor or volunteer, who may have contact with clients/residents (p. 6).

· Pre-Employment Questionnaire

Interviews:

Administrative (Human Resources) – The interviewed human resources staff reported that the facility considers prior incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Additionally, we do three reference checks, one professional and two personal. In addition, we send a good faith letter if they had prior institutional employers.

Corrective Actions:

· Pre-Employment Questionnaire: Prior to the conclusion of the interim report the auditor did not receive all of the requested documents on staff. The facility shall provide a copy of the pending documentations.

Corrective Action Taken: The facility provided documentation of a total of 20 staff pre-employment forms that were completed. The documentation was consistent with the requirements of the provision. No further action is needed.

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

115.317 (c). Before hiring new employees who may have contact with residents, the agency shall: (1) Perform a criminal background records check; (2) Consults any child abuse registry maintained by the State or locality in which the employee would work; and (3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse

Compliance Determination:

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

· The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility policies requires that before hiring new employees who may have contact with residents the agency shall: (1) Perform a criminal background records check; and (2) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. In the past 12 months, the number of persons hired who may have contact with residents who have had criminal background record checks: 34.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and

	Procedures Manual states that: Pathway will perform a criminal background record check and consult any child abuse registry maintained by Alabama prior to making any job offers to applicants working in Pathway's residential treatment facilities that will have contact with children. This policy also applies to contracted and volunteer workers. Prior to making a job offer to any applicant to work in Pathway's residential treatment programs, the applicant, in writing, shall authorize Pathway to contact all former employers for the past five years (prison, jail, lockup, community treatment facility, juvenile facility or other institution). Pathway personnel will make their best effort to contact these previous employers for information to inquire if the applicant engaged in sexual abuse or harassment of clients/residents or former clients/ residents during time of employment. Pathway personnel will make their best effort to contact all former institutional employers of the applicant employed within the required five-year period requesting information above (pp. 5-6). · Personnel Files New Hire Background Checks (5) · New Hire Reference Checks · Child Abuse Registry (20): The documentation was provided and reviewed, and it was determined that the agency conducts a child abuse registry check on all staff as a part of the employment process. Interviews: Administrative (Human Resources)- The interviewed human resources staff reported that the facility performs criminal record background checks or consider pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. The background check process includes local and national checks, child abuse registry checks, and reference checks. Corrective Actions: · Background Check/Reference Check: Prior to the conclusion of the interim report the auditor did not receive all of the requested documents on staff. The facility shall provide a copy of the pending documentations. Corrective Action Taken: Additional Background Checks were provided for 15 staff; showing the agency’s practice of completing background checks on new hires. The facility provided documentation of three staff who were hired in the past 12 months where reference checks were conducted on prior institutional employers. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.317 (d): The agency shall also perform a criminal background records check,

	and consult applicable child abuse registries, before enlisting the services of any contractor who may have contact with residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their response to the PAQ that agency policies require that a criminal background records check be completed before enlisting the services of any contractor who may have contact with residents. Consistent with employee background checks; criminal history background checks, including driver's license checks and fingerprinting, shall be conducted on all volunteers, interns, and persons working in the department on contract who have direct contact with offenders. In the past 12 months, the number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway will perform a criminal background record check and consult any child abuse registry maintained by Alabama prior to making any job offers to applicants working in Pathway's residential treatment facilities that will have contact with children. This policy also applies to contracted and volunteer workers" (p. 5). Interviews Administrative (Human Resources)— The interviewed human resources staff reported that the facility performs criminal record background checks or consider pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. Corrective actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.317 (e). The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ)

	that the facility either conducts criminal background records checks at least every five years of current employees and contractors who may have contact with residents or has in place a system for otherwise capturing such information for current employees. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway will conduct criminal background records checks at least every 5 years on current employees, contractors, and volunteers who have contact with clients/residents” (p. 6). Interviews: Administrative (Human Resources)-The interviewed human resources staff reported that the system the facility presently has in place to conduct criminal record background checks of current employees and contractors who may have contact with residents is a local, national, and child abuse registry check. Additionally, checks are done every five years. Corrective actions: · Corrective Action Plan: The facility was not up to date with the completion of 5-year checks in a timely manner. The agency shall complete 5-year background checks on employees. Additionally, the agency shall develop a plan to manage the process to ensure that the 5-year background checks are done in timely manner. Corrective Action Taken: The facility provided documentation for the two staff who had been employed at the agency for at least 5 years. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115. 317 (f). The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: · The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

	Interviews: Administrative (Human Resources) – The interviewed human resources staff reported that the facility asks all applicants and contractors who may have contact with residents about previous misconduct described in section (a)* in written applications for hiring or promotions, and in any interviews or written self-- -evaluations conducted as part of reviews of current employees. Corrective Actions: · Pre-Employment Questionnaire: Prior to the conclusion of the interim report the auditor did not receive all of the requested documents on staff. The facility shall provide a copy of the pending documentations. Corrective Action Taken: The facility provided documentation of a total of 20 staff pre-employment forms that were completed. The documentation was consistent with the requirements of the provision. No further action is needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.317 (g). Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According the to the PAQ, the agency's policy states that material omission regarding misconduct, or the provision of materially false information, shall be grounds for termination. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination" (p. 6). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.317 (h). Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Interviews: Administrative (Human Resources) – The interviewed human resources staff reported that when a former employee applies for work at another institution, upon request from that institution, the facility provides information on substantiated allegations of sexual abuse or sexual harassment involving the former employee, unless prohibited by law. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The corrective actions were completed and follow-up reviewed confirmed that the pending background checks, reference checks, and pre-employment questionnaire was updated. With these measures in place, the initial audit findings are resolved, and the facility is compliant with the provisions of the standard.

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) 2. Interviews:

	a. Agency head b. Director Findings (By Provision): 115.317 (a). When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility has not acquired a new facility or made substantial expansions or modifications to the existing facility since the last PREA audit. This is the first time the site was audited. The agency already had the existing facility; however, it was remission for juvenile justice youth. Interviews Agency Head – The interviewed agency head reported that We deploy video monitoring and attempt to identify any areas of concern that could prevent detection of abuse. Director– All of the above are considered in the design of the facility. This was considered when designing the IDI site, as well as hiring for the facility. Pathway ensured that there was video monitoring deployed and designed in the building to minimize areas in which abuse could be hidden form staff. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.316 (b). When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· The facility reported in the PAQ that they have not installed or updated its video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit. Interviews: Agency Head: The interviewed agency head reported that we deploy technology (whether video monitoring or advancements that improve supervision) in areas in need of such technology to prevent abuse and protect clients. These needs are regularly assessed by PREA Compliance Managers. Director: Video monitoring was already deployed prior to the audit. All areas where monitoring is allowed has cameras to provide monitoring for clients. Audio monitoring has been deployed on all new installs to increase monitoring effectiveness. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual

c. MOU Southeast Alabama Child Advocacy Center Dothan, AL

d. Counselor License

e. Email Correspondence SANE Hope Center at Southwest Health

f. MOU-Coffee County Sheriff's Office

g. Memo: PREA Investigation Procedures

2. Interviews:

a. Random sample of staff -8

b. PREA coordinator

c. Child Advocacy Center

d. PREA Compliance Manager

Findings (By Provision):

115.321 (a). To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

Compliance Determination:

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

· As reported in the PAQ, the agency/facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The agency/facility is not responsible for conducting criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The DHR/Local Law Enforcement is responsible for conducting criminal sexual abuse investigations. It was further reported that when conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that:

Pathway's residential treatment facilities will follow a uniform evidence protocol, that is developmentally appropriate for youth, which maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

Upon receiving a report of alleged sexual abuse, staff will notify their Supervisor and/or any other Supervisor up to and including: the PREA Coordinator, PREA Compliance Manager (Residential Program Director), Director, or the onsite program

	Supervisors. To the extent possible, staff shall attempt to secure the area to preserve any evidence that may assist the investigation process. Staff should document what was seen and heard, or otherwise observed at the scene, and safeguard any evidence (i.e., bed sheets, fluids on floor, victim's, and perpetrator's clothing). Allegations of sexual abuse or sexual harassment which involves potentially criminal behavior will be referred to the local law enforcement agency. Pathway will inform the victim of what will happen next (i.e. the incident will be reported to an available clinical supervisor, the PREA Compliance Manager and the PREA Coordinator, the victim will be offered a forensic medical examination off campus for evidence collection, an investigation will be conducted by the Department of Human Resources and/or the Baldwin County Sheriff's Office, the victim will be asked to provide information to the investigator, and the victim and any witnesses will be provided protections from retaliation). Staff will complete an incident report detailing initial information given to staff from the victim or third party. Staff should ask victim for only basic information about the incident (i.e., Who was there? What happened? Where did the incident occur? When?). The report shall be given to the PREA Compliance Manager and PREA Coordinator. The PREA Coordinator will ensure that the Chief Executive Officer is informed of any sexual abuse allegations and results of any investigations. Forensic medical examinations in the community will be provided free of charge to the victim. The victim will be provided with unimpeded access to emergency and crisis intervention services, which will also be provided free of charge to the victim. SANE Nurses are located at USA Women's and Children's Hospital. In the event that a SANE is unavailable, a forensic medical examination will be provided by a qualified medical practitioner. Victim advocates from the Baldwin County Child Advocacy Center can be available at the forensic medical examination. This service is available to all Pathway of Baldwin County clients. A Memorandum of Understanding (MOU) has been signed between Pathway and the Baldwin County Child Advocacy Center. If requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member can accompany and support the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals (pp. 8- 9). · Email correspondence with the victim advocacy center, confirmed the victim advocacy center identified by the agency contract can provide victim advocacy, emotional supportive, and forensic services for residents at the program. The program further indicated that they have not had to render services for residents at

	the program in the last 12 months. Interviews Random Sample of Staff: During the onsite audit, the random staff were asked, “Do you know and understand the agency’s protocol for obtaining usable physical evidence if an individual in custody alleges sexual abuse?” All interviewed staff were aware of the agency’s protocols. Staff were able to describe the process and steps required to protect physical evidence, which included separating the residents in custody, securing the area, protecting the physical evidence, not allowing the victim to shower or brush teeth, immediately seeking medical attention and contacting supervisor. All staff members reported varies responses regarding who is responsible for conducting sexual abuse investigations it includes: · Supervisors · Director · PREA Coordinator · DYS/Law Enforcement Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.321(b). The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents," or similarly comprehensive and authoritative protocols developed after 2011. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported by the PAQ, the protocol is developmentally appropriate for youth. The protocol was adapted from or otherwise based on the most recent edition of the DOJ’s Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: Pathway's residential treatment facilities will follow a uniform evidence protocol,

	that is developmentally appropriate for youth, that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Upon receiving a report of alleged sexual abuse, staff will notify their Supervisor and/or any other Supervisor up to and including: the PREA Coordinator, PREA Compliance Manager (Residential Program Director), Director, or the onsite program Supervisors. To the extent possible, staff shall attempt to secure the area to preserve any evidence that may assist the investigation process. Staff should document what was seen and heard, or otherwise observed at the scene, and safeguard any evidence (i.e., bed sheets, fluids on floor, victim's, and perpetrator's clothing). Allegations of sexual abuse or sexual harassment which involves potentially criminal behavior will be referred to the local law enforcement agency. Pathway will inform the victim of what will happen next (i.e. the incident will be reported to an available clinical supervisor, the PREA Compliance Manager and the PREA Coordinator, the victim will be offered a forensic medical examination off campus for evidence collection, an investigation will be conducted by the Department of Human Resources and/or the Baldwin County Sheriff's Office, the victim will be asked to provide information to the investigator, and the victim and any witnesses will be provided protections from retaliation). Staff will complete an incident report detailing initial information given to staff from the victim or third party. Staff should ask victim for only basic information about the incident (i.e., Who was there? What happened? Where did the incident occur? When?). The report shall be given to the PREA Compliance Manager and PREA Coordinator. The PREA Coordinator will ensure that the Chief Executive Officer is informed of any sexual abuse allegations and results of any investigations. Forensic medical examinations in the community will be provided free of charge to the victim. The victim will be provided with unimpeded access to emergency and crisis intervention services, which will also be provided free of charge to the victim. SANE Nurses are located at USA Women's and Children's Hospital. In the event that a SANE is unavailable, a forensic medical examination will be provided by a qualified medical practitioner. Victim advocates from the Baldwin County Child Advocacy Center can be available at the forensic medical examination. This service is available to all Pathway of Baldwin County clients. A Memorandum of Understanding (MOU) has been signed between Pathway and the Baldwin County Child Advocacy Center. If requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member can accompany and support the victim through the forensic medical examination process and investigatory

	interviews and provides emotional support, crisis intervention, information, and referrals (pp. 8- 9). · The Advocacy Center utilized by the agency is under the umbrella of the Alabama Network of Children's Advocacy Centers Inc.; which is recognized by the National Network of Children's Advocacy Center, which is now the National Children's Alliance. The advocacy center operates under the national practices and standards. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.321 (c). The agency shall offer all residents who experienced sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire that the facility offers all residents who experience sexual abuse access to forensic medical examinations at an outside facility and that there is no charge for these examinations. The facility responded that forensic medical examinations are offered without financial cost to the victim. It was further reported that when SANEs or SAFEs are not available, they offer a qualified medical practitioner to perform forensic medical examinations. The number of forensic medical exams conducted during the past 12 months: 0. The number of exams performed by SANEs/SAFEs during the past 12 months: 0. The number of exams performed by a qualified medical practitioner during the past 12 months: 0. · Policy. 13.8.1 (Protection from Sexual Abuse and Assault) states that "The facility shall offer all juveniles who experience sexual abuse access to forensic medical examinations without financial cost. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The facility shall document its efforts to provide SAFEs or SANEs" (p. 9). · MOU: Southeast Alabama Child Advocacy Center states that the Child Advocacy Center will accompany a youth during the forensic examination process.

	· MOU: Southeast Alabama Child Advocacy Center states that the Child Advocacy Center will accompany a youth during the forensic examination process. Additionally, the MOU provides an overview of the victim advocacy and emotional support services that the child advocacy center will provide to any referred victim. Interviews Child Advocacy Center- Email correspondence with the victim advocacy center, confirmed the victim advocacy center identified by the agency contract can provide victim advocacy, emotional supportive, and forensic services for residents at the program. The program further indicated that they have not had to render services for residents at the program in the last 12 months. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.321 (d). The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire that it has made attempts to make available to the victim, a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the facility makes available to provide these services a qualified staff member from a community-based organization, or a qualified facility staff member. · MOU: Southeast Alabama Child Advocacy Center states that the Child Advocacy Center will accompany a youth during the forensic examination process. Additionally, the MOU provides an overview of the victim advocacy and emotional support services that the child advocacy center will provide to any referred victim. · Counselor License: provide a license for staff that qualify within the agency to provide victim advocacy services if a community-based organization is not available.

	· Email correspondence with the victim advocacy center, confirmed the victim advocacy center identified by the agency contract can provide victim advocacy, emotional supportive, and forensic services for residents at the program. The program further indicated that they have not had to render services for residents at the program in the last 12 months. Interviews: PREA Compliance Manager – The agency or facility will attempt to make available a victim advocate from a rape crisis center, by coordinating services. We have an agreement with the CAC but usually DHR sets up an appointment with the CAC and will transport the residents. We have state approved child advocacy center. Residents who Reported a Sexual Abuse – There were no identified residents during the onsite portion of the audit, which reported a sexual abuse. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.321 (e). As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire that they would provide, if requested by the victim, a victim advocate, a qualified agency staff member, or a qualified community-based organization staff member to accompany and support the victim through the forensic medical examination process and investigatory interviews and to provide emotional support, crisis intervention, information, and referrals. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member can accompany and support the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals” (p. 9). · MOU: Southeast Alabama Child Advocacy Center states that the Child Advocacy Center will accompany a youth during the forensic examination process.

Additionally, the MOU provides an overview of the victim advocacy and emotional support services that the child advocacy center will provide to any referred victim.

· Email correspondence with the victim advocacy center, confirmed the victim advocacy center identified by the agency contract can provide victim advocacy, emotional supportive, and forensic services for residents at the program. The program further indicated that they have not had to render services for residents at the program in the last 12 months.

Interviews:

PREA Compliance Manager – The agency or facility will attempt to make available a victim advocate from a rape crisis center, by coordinating services. We have an agreement with the CAC but usually DHR sets up an appointment with the CAC and will transport the residents. We have state approved child advocacy center.

Residents who Reported a Sexual Abuse - There were no identified residents during the onsite portion of the audit, which reported a sexual abuse.

Corrective Actions:

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

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

115.321 (f). To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section.

Compliance Determination:

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

· The agency is not responsible for conducting criminal investigations. There scope of service for investigations is limited to administrative investigations.

· The agency provided an MOU with Coffee County Sheriff’s Office stating that the Sheriff’s Office will conduct investigations on allegations of sexual abuse and sexual harassment.

Corrective Actions:

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

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

115.321 (g). The auditor is not required to audit this section.

115.321 (h). For the purposes of this standard, a qualified agency staff member or a

	qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency provided documentation of four staff how are licensed Professional Counselors. The staff are licensed in the state of Alabama. The agency staff would serve as liaisons to coordinate services with the child advocacy center. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations.

115.322	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Website: PATHWAY - Services (pathway-inc.com) d. Investigations (3) 2. Interviews: a. Agency head

b. Investigative staff - 2

Findings (By Provision):

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

Compliance Determinations:

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

· As reported in the PAQ, the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that:

Sexual Harassment: When allegations of sexual harassment are made, investigations shall take place under the following guidelines:

Client/Resident to Client/Resident: The PREA Compliance Manager, his/her designee or the PREA Coordinator shall investigate questioning all parties involved to determine what happened and direct action to prevent further incidents. The Department of Youth Services and Department of Human Resources and all other licensing authorities will be notified of the findings and the PREA Compliance Manager/designee or PREA Coordinator shall file appropriate reports.

Staff to Client/Resident: The PREA Compliance Manager, designee and the PREA Coordinator shall investigate, questioning all relevant parties to determine what happened. The Department of Youth Services and Department of Human Resources and all other licensing authorities will be notified of the findings and consulted in determination of actions to be taken.

If the PREA Compliance Manager is involved in the allegations: His/her immediate supervisor shall conduct the investigation as noted above.

Sexual Abuse: When allegations of sexual abuse/assault are made, the following shall happen:

Contact local authorities immediately, if a client/resident reports a sexual assault. If the PREA Compliance Manager or PREA Coordinator is available, he/she shall take responsibility for contacting authorities. If the PREA Compliance Manager is not available, on duty staff must contact authorities without delay.

If the allegations or quality of evidence suggest a crime has been committed, no further interview of the victim or perpetrator will be conducted until cleared to do so by prosecuting authority.

	Pathway will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. If there is a possibility of new physical evidence to be used: Secure the area where the alleged abuse took place and do not allow residents to enter the area until police personnel have cleared the area; Do not touch anything in the area where the alleged abuse took place other than to preserve the life or safety of an individual; Move the alleged victim to a secure area until authorities arrive; If conditions allow, direct the alleged perpetrator to remain in an area where they can be observed until authorities arrive; Pathway staff shall cooperate with all aspects of the investigation by local authorities. The PREA Compliance Manager and PREA Coordinator shall endeavor to remain informed about the progress of the investigation and notify all program licensing authorities; PREA Compliance Manager/designee or PREA Coordinator shall conduct administrative investigation; Any substantiated allegations of conduct that appears criminal will be referred for prosecution (pp. 19-20). In the past 12 months, the number of allegations of sexual abuse and sexual harassment that were received: 3. In the past 12 months, the number of allegations resulting in an administrative investigation: 3. In the past 12 months, the number of allegations referred for criminal investigation: 0. · Investigation Reports: The auditor reviewed three reported allegations of sexual harassment. All allegations were administratively investigated. The investigations were completed to include findings Interviews Agency Head: The interviewed agency head stated that the agency ensures that administrative or criminal investigations are completed for all allegations of sexual abuse or sexual harassment. This is determined by the nature of the allegation; however, if the initial investigation does not indicate a need for a criminal investigation the following procedure is followed: PREA Compliance Managers will gather information from the alleged victim, review camera footage, and speak with necessary staff members to ensure they have all needed information to conclude the investigation. Decisions are then made about disciplinary action from there.

	Clients are notified of the results of the investigation promptly. Clients may also be separated to keep the alleged victim safe until the investigation is complete. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.322 (b). The agency shall have in place a policy to ensure that allegations of sexual abuse and/or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. In addition, the facility reported in the PAQ that the agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is not published on the agency website or made publicly available via other means. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway shall conduct its own investigations into allegations of sexual harassment and abuse that do not involve behavior that could potentially be criminal in nature. It shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. At any point if it is determined that the allegation could potentially involve criminal behavior, a report will be made immediately to local law enforcement agency as well as the Department of Human Resources" (p. 21). · Three allegations of sexual harassment were reviewed to determine if the referrals for allegations were documented. All three referrals were immediately documented and investigated. · The investigation process of the policy is posted on the website offering public availability. (PATHWAY - Services (pathway-inc.com)) Interviews Investigative Staff: The interviewed staff reported that the policy requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. Criminal cases

	are referred to local law enforcement. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.322 (c). If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency website states that “Any allegation of sexual abuse that potentially involves criminal behavior shall be turned over the jurisdictional Police Department for investigation, especially in all cases that may have happened within a time frame that allows for collection of physical evidence or if the allegation involves another staff member.” PATHWAY - Services (pathway-inc.com). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.322 (d). The auditor is not required to audit this provision of the standard. 115.322 (e). The auditor is not required to audit this provision of the standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.331	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Acknowledgement and Receipt of PREA Training (20) d. Acknowledgement and Receipt of PREA Refresher Training Log (5) e. Mandatory Reporter Certificates (15) f. Training Documents: i. Unit 3 Response and Reporting ii. Unit 3 Prevention and Detection iii. Unit 2 Client Rights iv. Unit 1 PREA Overview v. Unit 4 Professional Boundaries vi. Unit 5 Effective Communication vii. Mandated Reporters Training 2. Interviews: a. Random sample of staff - 8 Findings (By Provision): 115.331 (a). The agency shall train all employees who may have contact with residents on:(1) Its zero-tolerance policy for sexual abuse and sexual harassment;(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;(3) Residents' right to be free from sexual abuse and sexual harassment;(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;(5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;(8) How to avoid inappropriate relationships with residents;(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;(11) Relevant

	laws regarding the applicable age of consent. It should be noted that the facility opened in the last 12 months; a majority of the staff are all new hires. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency trains all employees who may have contact with residents in the following matters: · The agency’s zero-tolerance policy for sexual abuse and sexual harassment; · How staff fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; · Residents right to be free from sexual abuse and sexual harassment; · The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; · The dynamics of sexual abuse and sexual harassment in resident facilities; · The common reactions of sexual abuse and sexual harassment victims; · How to detect and respond to signs of threatened and actual sexual abuse; · How to avoid inappropriate relationships with residents; · How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; · How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.; and · Relevant laws regarding the applicable age of consent. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: Staff Training Pathway employees will receive training, based on PREA employee training standards. All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards. Pathway shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. During the years in which an employee does not receive refresher training, Pathway shall provide refresher information on current sexual abuse and sexual harassment policies. Upon hire and annually thereafter, Pathway will provide targeted PREA training on

	the following: Pathway's zero-tolerance policy for sexual abuse and sexual harassment; Pathway's sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; Clients'/Residents' rights to be free from sexual abuse and sexual harassment; The right of clients/residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; The dynamics of sexual abuse and sexual harassment in a residential treatment facility; The common reactions of sexual abuse and sexual harassment victims; How to detect and respond to signs of threatened and actual sexual abuse; How to avoid inappropriate relationships with clients/residents; How to communicate effectively and professionally with clients/residents, including gay, bisexual, transgender, intersex, or gender nonconforming residents; and How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Relevant laws regarding the applicable age of consent. Gender specific training will be provided to the gender of the residents at the employee's facility. Pathway will document, through employee signature or electronic verification, that employees understand the training they have received. Training participation may be offered in-house, online, webinars, conferences, etc. Training topics will be added and offered based upon the annual training needs as assessed by the PREA Compliance Manager and the PREA Coordinator. Pathway will provide training as needed for staff to conduct administrative investigations (pp. 9-10). · Training Curriculum: The agency utilizes the PREA Employee Training Curriculum, available through the PREA Resource Center. · Sample of Training Record: New Hire (20); Refresher (5); Mandatory Reporter (15). The agency has a process were training is documented for PREA New Hire, Refresher and Mandatory Reporter Training. Interviews Random Sample of Staff – All of the interviewed random sample of staff reported

	that they have been trained on the agencies zero tolerance policy for sexual abuse or sexual harassment. The staff reported that the training included the below elements: 1) During employee orientation and annually, staff shall receive the following PREA training: a. The facility's zero tolerance for all forms of sexual abuse and sexual harassment. b. How to fulfill their responsibilities in regard to prevention, detection, reporting, and response. c. The resident's right to be free from of sexual abuse and sexual harassment. d. The resident's and staff member's right to be free from retaliation for reporting sexual abuse and sexual harassment e. The dynamics of sexual abuse and sexual harassment in residential settings, including determining which residents are most vulnerable. f. The common reactions of sexual assault or sexual abuse victims g. How to avoid inappropriate relationships with residents h. How to communicate effectively and professionally with all residents and i. How to comply with relevant laws related to the mandatory reporting of sexual abuse to authorities. When probed the staff could elaborate on the signs and what to look out for if someone is being victimized, and some of the dynamics of sexual abuse and sexual harassment in confinement settings. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.331 (b). Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa. Compliance Determination: · The facility reported in the PAQ that training is tailored to meet the unique needs and attributes and gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are not given additional

training.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Gender specific training will be provided to the gender of the residents at the employee's facility” (p. 10).

· Sample of Training Record: New Hire (20); Refresher (5); Mandatory Reporter (15). The agency has a process were training is documented for PREA New Hire, Refresher and Mandatory Reporter Training.

Corrective Actions:

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

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

115.331 (C). All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

Compliance Determination:

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

· As reported in the PAQ, between trainings the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and harassment. The frequency with which employees who may have contact with residents receive refresher training on PREA requirements: Annually.

· Sample of Training Record: Refresher (5); The agency has a process were training is documented for Refresher Training. It should be noted that the facility opened within the last year and most staff are new hires.

Corrective Actions:

The facility should provide a roster or a sign in sheet for the annual refresher training.

115.331 (d). The agency shall document, through employee signature or electronic verification, that employees understand the training they have received.

Compliance Determinations:

The facility has demonstrated compliance with this provision of the standard

	because: · The PAQ indicated that the facility requires employees who may have contact with residents to document, via signature, that they understand the training they received. The facility will have the service providers, volunteers, and non-detention juvenile office staff sign an agreement acknowledging the facilities zero tolerance policy for sexual abuse and sexual harassment along with the duty to report. · Training Acknowledgement: The agency ensures that employees who may have contact with residents confirm their understanding of the training received through either a signature or electronic verification. This acknowledgment is documented via the Acknowledgement and Receipt of PREA Training form. (20) Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: Documentation: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Training Curriculum 2. Interviews:

	a. Volunteers or contractors who have contact with residents – There were no volunteers or contractors. 115.332 (a). The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According to the PAQ, all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The number of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 0. Interviews: Volunteer(s) or Contractor(s) who have Contact with Residents: There were no volunteers or contractors during the onsite audit. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.332 (b). The level and type of training provided to volunteers and contractors shall be based on the services they provided and level of contact they have with residents, but all volunteer and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ, that all volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. · Volunteer Training Curriculum: (Volunteer Contractor PREA Training Policy): While the site does not have any volunteers or contractors in the event there was one the person would complete the training and sign acknowledgement of

	understanding and receipt. Interviews: Volunteer(s) or Contractor(s) who have Contact with Residents: There were no volunteers or contractors during the onsite audit. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.332 (c). The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains documentation confirming that the volunteers and contractors understand the training they have received. However, this time they site does not have any volunteers or contractors. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.333	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents:

	a. Pre-Audit Questionnaire (PAQ) b. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Intake Records PREA Education: Juvenile Confirmation of Receipt of Prison Rape Elimination Act (PREA) (18) d. PREA Posters (English/Spanish) e. Resident Handbook f. Resident Orientation Acknowledgement (19) g. PREA Video (MP4) 2. Interviews: a. Intake staff - 1 b. Random sample of residents - 10 3. Site Review 4. Corrective Action: a. Updated Handbook- b. Updated PREA Signage c. Updated Victim Advocacy and emotional Support Signage d. Additional Resident Orientation Acknowledgment (6) e. Language Line Posting f. Verification of Enrollment (2) Findings (By Provision): 115.333 (a). During the intake process, residents shall receive information explaining, in an age-appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment.

	The number of residents admitted in past 12 months who were given this information at intake: 35. It was further reported that the information is provided in an age-appropriate fashion. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “During the intake process, clients/residents shall receive information explaining Pathway's zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. This information is provided in an age-appropriate format to ensure understanding and to meet the needs of clients who have limited reading skills or other needs requiring an interpreter” (p. 11). · Resident Handbook states: If you need to report sexual harassment, sexual abuse, staff sexual misconduct, retaliation by other clients or staff members for reporting sexual abuse/harassment/ misconduct, or staff neglect that may have contributed to any of the above incidents, you can use the following reporting methods: · Make a written report by completing a Grievance Form, which can be turned into to the PREA Compliance Manager/Program Director · Make a verbal report by asking to speak with your therapist, the shift leader on duty, or the PREA Compliance Manager/Program Director · Make a written or verbal report to any staff member that you trust (Group leader, Teacher, Nurse, Food Service Staff, etc.) · Ask to call the Rape Crisis Hotline · Report anonymously to Pathway by completing a Grievance Form without signing the form and placing the form in the locked Grievance Box · Report anonymously to a third party by writing a letter/filling out an unsigned grievance form and placing it in a pre-addressed/stamped envelope that will be provided to you at intake. You can place this envelop in the locked Grievance Box If you have experienced sexual abuse or sexual harassment at Pathway, we will provide you with access to a victim advocate from the Child Advocacy Center upon request who will provide emotional support services throughout the investigative process. To request access to a victim advocate, speak with your therapist or make a written request to your therapist, or the PREA Compliance Manager (Mr. Herman). · Intake records of residents entering the facility in the last 12 months (19). · Log or other record corroborating that those residents received comprehensive PREA education within 10 days of intake (e.g., resident signatures).

· In addition to the Resident Handbook, the facility utilizes a Resident Education PREA Video, and PREA Poster to educate the residents on Sexual Abuse and Sexual Harassment. The PREA Video was created by the PREA Resource Center containing general information on residents' rights to not be sexual abused or harassed, retaliated against for making a report, and that there are services available that deal with sexual abuse. The PREA Posters have a definition of sexual abuse and various ways to make a report.

· During the intake process the residents sign the PREA Acknowledgement and the acknowledgement provides the following information: "I have been provided a formal training on the Prison Rape Elimination Act and the expectations. I understand my rights and responsibilities with regard to physical and emotional safety. I have been taught ways to protect myself. The definitions of abuse and harassment have been explained to me. I have been informed how to report abuse and/or harassment. I will not abuse or harass any person (staff or other youth) and I will report if I feel or see that harassment or abuse is happening. This includes all types of harassment. I understand the meaning of retaliation. I understand that retaliation will not occur if I report abuse and/or harassment."

Site Review

Intake Process Observation:

During the site review, the auditor confirmed that the intake process is managed by the mental health staff, who are stationed in the residents' unit.
Although there were no new intakes during the audit, a mock intake was conducted by a mental health staff member, revealing the following:
Written materials, including the PREA Client Handbook and the Facility Rules Handbook, are provided at an appropriate reading level and are accessible to all residents, including those with limited English proficiency (LEP). These handbooks are available in both English and Spanish.
The intake/mental health staff demonstrated the various ways in which they notify a resident that they can make a report. Such was described included: writing a note grievance and giving it to any staff, telling any staff, writing a DYS grievance and leaving in the DYS box, tell their parents, attorneys, or someone they trust and they can report for them, and that they could anonymously make such reports.
The facility offers interpreter services when needed, including for Deaf and non-English speaking residents. The intake staff reported that they would coordinate with the facility director to arrange these services if required.
During the mock intake, the staff demonstrated how they review the PREA Client Handbook and Facility Rules Handbook with residents, asking follow-up questions to ensure comprehension. They also request residents to provide examples to confirm their understanding.
The intake staff showed the auditor how they present the PREA video to residents as part of the orientation process.
The mental health staff are responsible for educating residents on the facility's rules regarding sexual abuse and harassment during intake.
It should also be noted that during intake the residents receive information about

	mandatory reporting requirements and the limitations to confidentiality. The staff demonstrated that once they go over the documents the residents watch the PREA video and sign acknowledging receipt of information. The auditor was able to observe how the residents electronically sign on a signature pad. Informal Conversations: Informal conversations with residents confirmed that the mental health staff reviewed the PREA-related information and showed them a video during the intake process. INTERPRETATION SERVICES · While the facility did not have any residents who were limited English Speaking, the auditor was able to test securing interpretation services on-demand. o The auditor contacted the language line and spoke to the staff on the process to access on demand languages. The staff table walked the auditor through the process so the site would not be charged for the use of services. We went through providing the pin and the prompts for various languages. There are nine languages available for on-demand services and any other language would have to be requested. · While the residents would not have to self-identify the facility would have to enter a pin number to access the contract on-demand services. The residents at the facility do not have access to a phone at any given time, therefore accessing such services would be limited to staff request for services. · The interpreter services are available 24/7 with staff assistance to access the line. · As described by the Clinician, in coordination with the Director the language line services would be accessed and the use of the interpreter would occur in a closed door in the Clinician Office. Additionally: · During informal and formal conversation with the mental health staff who conduct intake it was reported that if interpreter services were needed, they would coordinate with the facility director to access the services. As of the facility opening, they have not had to access interpreter services. Interviews Intake Staff: The interviewed staff that performs intake duties stated that during admission to the facility all youth are provided information regarding agency’s zero tolerance policy for sexual abuse or sexual harassment. During the intake process, the residents are provided an assessment, PREA Acknowledgement form as well as given a handout regarding prevention and reporting sexual abuse or sexual harassment. Residents will watch the PREA video and I will go over the handbook with them, have them electronically sign acknowledgment and give them a copy of

	the handbook. The information is verbally given to them and then I will ask to follow up questions to ensure their understanding. Residents(s) in custody Interview Questionnaire: Ten residents in custody were interviewed All of the interviewed residents reported that upon arrival they were given information about the facilities rules against sexual abuse and harassment. The residents discussed various methods in which the received the information, to include staff telling them, PREA video, and a handbook. Corrective Actions: · The facility provides information at intake through the PREA brochure, handbook and PREA video. The Manual is not up to date and has contact information for staff that do not work at the facility. The facility shall update the manual with the correct information. Due Date: 11/1/2024 Corrective Action Implemented: The handbook was updated removing specific names of staff and listing the titles of the positions associated as a point of contact No further action needed. · While the facility exhibited substantial compliance with completing the PREA education at intake. There was one identified resident file that was determined to not be in compliance. The auditor will monitor for a two-month period to ensure that the practice is consistently being conducted. Due Date: 11/30/2024 (New Intakes in September and October) Corrective Action Implemented: During the correction phase the facility provided documentation of new intake orientation. There were two youth whose intake date appeared out of range; however, it is because the system was picking up the initial intake date from a prior intake. In addition to the documentation of orientation that was provided (6) there are two additional documents enrolled to verify the correct intake date. The documentation provided was consistent with the requirements of the provision, no further action required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.333 (b). Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ, 35 residents that were admitted in the facility during the past 12 months, who's length of stay was for 10 days or more received comprehensive education regarding their right to be free from both sexual abuse/ harassment and retaliation for reporting such incidents and on agency policies and procedures for responding to such incidents. · Resident Education Documentation: The facility tracks resident participation in education sessions through the completion of the Resident Orientation Acknowledgement Form. During the mock intake process, the auditor observed residents signing electronically upon completion of the education. The auditor also reviewed 20 signed Resident Orientation Acknowledgement forms. · PREA Intake Video: the site utilizes the PREA video created by the PREA Resource Center as a part of their PREA educational session. Residents review the video during intake. Intake typically occurs on the first day of placement. · Revised Handbook states the following: If you need to report sexual harassment, sexual abuse, staff sexual misconduct, retaliation by other clients or staff members for reporting sexual abuse/harassment/ misconduct, or staff neglect that may have contributed to any of the above incidents, you can use the following reporting methods: · Make a written report by completing a Grievance Form, which can be turned into to the PREA Compliance Manager/Program Director · Make a verbal report by asking to speak with your therapist, the shift leader on duty, or the PREA Compliance Manager/Program Director · Make a written or verbal report to any staff member that you trust (Group leader, Teacher, Nurse, Food Service Staff, etc.) · Ask to call the Rape Crisis Hotline · Report anonymously to Pathway by completing a Grievance Form without signing the form and placing the form in the locked Grievance Box · Report anonymously to a third party by writing a letter/filling out an unsigned grievance form and placing it in a pre-addressed/stamped envelope that will be provided to you at intake. You can place this envelop in the locked Grievance Box If you have experienced sexual abuse or sexual harassment at Pathway, we will provide you with access to a victim advocate from the Child Advocacy Center upon request who will provide emotional support services throughout the investigative process. To request access to a victim advocate, speak with your therapist or make a written request to your therapist, the PREA Compliance Manager (Mrs. Grace), or the PREA Coordinator (Mrs. Kimmy). o · Additional Posting (Advocacy and Emotional Support). The following postings

	were created and posted in the facility as a corrective action. The postings contained the following information: pathway provides victim advocacy through southeast child advocacy center, which includes the following for sexual abuse or sexual assault victims: · Medical care to any sexual abuse or assault victim · Sexual Assault Forensic Examinations · Forensic interviews · Contact with a victim advocate via phone or in person visits · Follow-up services and crisis intervention contacts as necessary *** A supervisor or therapist will listen to calls made to victim advocacy, so what you say might not be completely private. ***Pathway staff and Victim advocates have to report any crimes or possible Harm to the right people. SOUTHEAST CHILD ADVOCACY CENTER 110 Harmony Lane Dothan, AL 36303 (334) 671-1779 Site Review Although no new intakes occurred during the audit, a mental health staff member conducted a mock intake, revealing the following: · Facility Type: the facility serves as a residential medium risk site. The facility is designed similar to a community residential program. The facility is not hardwired, and residents that are placed at the program, or pre-approved based on the program criteria. Resident placement is planned, and the facility has pre-knowledge of when a placement will occur. · Written Materials: The PREA Client Handbook and Facility Rules Handbook are provided at an appropriate reading level and are accessible to all residents, including those with limited English proficiency (LEP). These handbooks are available in both English and Spanish. · Interpreter Services: The facility offers interpreter services when needed, including for Deaf and non-English speaking residents. Intake staff coordinate with the facility director to arrange these services as required. The language line offers on demand services 24/7 for nine languages, and additional language services as requested.

	· Mock Intake Demonstration: During the mock intake, staff demonstrated how they review the PREA Client Handbook and Facility Rules Handbook with residents. They ask follow-up questions and request residents to provide examples to ensure comprehension. · PREA Video Presentation: The intake staff also showed the auditor how they present the PREA video to residents as part of their orientation. The PREA Video covers information about residents right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents. The staff demonstrated that once they go over the documents the residents watch the PREA video and sign acknowledging receipt of information. The auditor was able to observe how the residents electronically sign on a signature pad. · PREA Client Handbook Contents: The auditor confirmed that the PREA Client Handbook includes detailed information on the following topics: o Overview of PREA o Facility Rules o Understanding Relationships o Healthy vs. Unhealthy Relationships o Defining Sexual Assault o Preventing Sexual Assault o Safety Guidelines o Steps to Take if Sexually Assaulted o Addressing False Allegations o Legal Implications of Sexual Assault o Consequences for Perpetrating Sexual Assault o Risks of Contracting STDs o Facts About Sexual Assault Interviews Intake Staff: One staff member was interviewed that performs intake duties. Staff stated that during admission to the facility all youth are provided information regarding agency’s zero tolerance policy for sexual abuse or sexual harassment. During the intake process, the residents are given information via a video, verbal, and a handbook. Residents sign a PREA Acknowledgement form as well as given a copy of the handbook. Finally, all residents electronically sign acknowledgement. Intake is done on the same day of arrival into the facility. While they have not had a disabled or limited English-speaking resident, if needed we would obtain an

	interpreter. Residents(s) in custody Interview Questionnaire: Ten residents in custody were interviewed. All of the residents reported that upon arrival at the facility they were told about their right not to be sexually abused or sexually harassed, how to report sexual abuse or sexual harassment, and their right not to be punished for reporting sexual abuse or sexual harassment. The information was provided on the first day by staff and the resident was able to describe receiving a handbook and watching the PREA video. Corrective Actions: · During the site review, the auditor found that residents were not adequately informed about victim advocacy and emotional support services. Although there were postings on the walls, residents were unaware of the services available and how to access them. The facility will develop a plan to incorporate information about advocacy and emotional support services into the intake process and conduct a group session with current residents to educate them on these services. Additionally, the facility must provide documentation confirming that the group session occurred and that these services were integrated into the intake process. Corrective Action Implemented: During the site review, the facility added additional postings in the housing areas providing information on victim advocacy and emotional support services. Additionally, the site incorporated documenting information on advocacy and emotional support in the orientation process. · The facility provides information at intake through the PREA brochure, handbook and PREA video. The Manual is not up to date and has contact information for staff that do not work at the facility. The facility shall update the manual with the correct information. Due Date: 11/1/2024 Corrective Action Implemented: The handbook was updated, removing specific names of staff and listing the titles of the positions associated as a point of contact No further action needed. · While the facility exhibited substantial compliance with completing the PREA education at intake. There was one identified resident file that was determined to not be in compliance. The auditor will monitor for a two-month period to ensure that the practice is consistently being conducted. Due Date: 11/30/2024 (New Intakes in September and October) Corrective Action Implemented: During the correction phase the facility provided documentation of new intake orientation. There were two youth whose intake date appeared out of range; however, it is because the system was picking up the initial intake date from a prior intake. In addition to the documentation of orientation that was provided (6) there are two additional documents enrolled to verify the correct intake date. The documentation provided was consistent with the requirements of

	the provision, no further action required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.333 (c). Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, all residents received PREA related education within 10 days of being placed at the facility. Additionally, residents transferred from another facility will receive PREA education upon intake and during orientation. It was further reported that the residents receive PREA education within the date of admission. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Clients/Residents who are transferred from one facility to another shall be educated regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents. All Pathway facilities follow the same policies and procedures regarding responding to such incidents” (p. 11). · Resident Education Documentation: The facility tracks resident participation in education sessions through the completion of the Resident Orientation Acknowledgement Form. During the mock intake process, the auditor observed residents signing electronically upon completion of the education. The auditor also reviewed 19 signed Resident Orientation Acknowledgement forms. It was further reported by the staff and residents the review of resident education and occurs on the first day of placement at the facility. Interviews Intake Staff: One staff member was interviewed that performs intake duties. Staff stated that during admission to the facility all youth are provided information regarding agency’s zero tolerance policy for sexual abuse or sexual harassment. During the intake process, the residents are provided information via a video, verbally, and a handbook. The staff reported that they will talk to the resident to ensure their understanding of the information provided. Follow up will occur, by asking them to explain the information that was provided to them. Corrective Actions: N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.333 (d). The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As indicated in the PAQ, resident PREA education is not available in formats accessible to all residents, including those that are: limited English proficient (LEP), deaf, visually impaired, otherwise disabled, limited in their reading skills. It was further reported that the clients admitted to this program would not be eligible for admission if there was an identified disability or LEP. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “explaining Pathway's zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. This information is provided in an age-appropriate format to ensure understanding and to meet the needs of clients who have limited reading skills or other needs requiring an interpreter. Pathway is an intense, cognitively demanding treatment program. As such, Pathway will provide resident education in formats accessible to all residents; however, Pathway's Diversion treatment program cannot accommodate those who are limited English proficient, deaf, visually impaired, or otherwise disabled” (p. 11). · PREA Posters (English/Spanish): The posters were updated during the post-onsite audit phase to a format consistent with a fifth-grade reading level. Additionally, the PREA Coordinator noted that residents with disabilities are not eligible for placement in the program. The posters are available in English and Spanish · Written Materials: The PREA Client Handbook and Facility Rules Handbook are provided at an appropriate reading level and are accessible to all residents, including those with limited English proficiency (LEP). These handbooks are available in both English and Spanish. · Interpreter Services: The facility offers interpreter services when needed, including for Deaf and non-English speaking residents. Intake staff coordinate with the facility director to arrange these services as required. The language line offers on demand services 24/7 for nine languages, and additional language services as requested.

	· PREA Video Presentation: The intake staff also showed the auditor how they present the PREA video to residents as part of their orientation. The PREA Video covers information about residents right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents. The staff demonstrated that once they go over the documents the residents watch the PREA video and sign acknowledging receipt of information. The auditor was able to observe how the residents electronically sign on a signature pad. For the immediate, the PREA video is available to residents who have a reading disability as they can audio learn the information. In addition, the staff and residents reported that the mental health staff verbally goes overall documentation and asks to follow up questions for knowledge and understanding. Corrective Actions: · Corrective Action: Update posters so they are in an age-appropriate reading level. Corrective Action Implemented: During the post onsite audit phase, the PREA posters were updated to adjust the language to a middle school reading level. · Corrective Action: Provided accessible information to the staff on language line services. The auditor requested that the facility place information about the language line services in common areas for staff and residents to access if needed. The facility shall provide documentation of the postings. Corrective Action Implemented: The facility provided documentation of where the language line information was posted throughout the facility. No further action is needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.333 (e). The agency shall maintain documentation of resident participation in these education sessions. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains documentation of resident participation in the PREA education sessions. · Resident Education Documentation: The facility tracks resident participation in education sessions through the completion of the Resident Orientation Acknowledgement Form. During the mock intake process, the auditor observed residents signing electronically upon completion of the education. The auditor also reviewed 19 signed Resident Orientation Acknowledgement forms. Corrective Actions:

	· N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.333 (f). In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Compliance Determination: · The facility reported in the PAQ that the agency will ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. · Resident Handbook states: If you need to report sexual harassment, sexual abuse, staff sexual misconduct, retaliation by other clients or staff members for reporting sexual abuse/harassment/ misconduct, or staff neglect that may have contributed to any of the above incidents, you can use the following reporting methods: · Make a written report by completing a Grievance Form, which can be turned into to the PREA Compliance Manager/Program Director · Make a verbal report by asking to speak with your therapist, the shift leader on duty, or the PREA Compliance Manager/Program Director · Make a written or verbal report to any staff member that you trust (Group leader, Teacher, Nurse, Food Service Staff, etc.) · Ask to call the Rape Crisis Hotline · Report anonymously to Pathway by completing a Grievance Form without signing the form and placing the form in the locked Grievance Box · Report anonymously to a third party by writing a letter/filling out an unsigned grievance form and placing it in a pre-addressed/stamped envelope that will be provided to you at intake. You can place this envelop in the locked Grievance Box If you have experienced sexual abuse or sexual harassment at Pathway, we will provide you with access to a victim advocate from the Child Advocacy Center upon request who will provide emotional support services throughout the investigative process. To request access to a victim advocate, speak with your therapist or make a written request to your therapist, or the PREA Compliance Manager. · A copy of the resident hand is provided to the residents at intake. Additionally, the handbook is posted in the common area of each housing area. · PREA Posters on how to report along with the victim advocacy and emotional support posters are located in the common areas of the housing units. Additionally,

	the PREA posters and how to report was located in the education building. Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: Initially, the signage was too complex for the average resident. However, it has been updated to a middle school reading level for better understanding. Signage about emotional and victim advocacy support services was not available at first. During the review, the site added new signage detailing these services and how to access them by phone or mail. Signage is available in both English and Spanish. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. The agency site contact information needed to be updated. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. The resident area consists of three buildings (2 housing units and an education building). Signage was placed in all locations. Additionally, residents had a copy of their handbook in their designated room. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. Corrective Actions: · During the site review, the auditor found that residents were not adequately informed about victim advocacy and emotional support services. Although there were postings on the walls, residents were unaware of the services available and how to access them. The facility will develop a plan to incorporate information about advocacy and emotional support services into the intake process and conduct a group session with current residents to educate them on these services. Additionally, the facility must provide documentation confirming that the group session occurred and that these services were integrated into the intake process.

	Corrective Action Implemented: During the site review, the facility added additional postings in the housing areas providing information on victim advocacy and emotional support services. Additionally, the facility incorporated educating residence about victim advocacy and emotional support at intake and documenting on the orientation process. · The facility provides information at intake through the PREA brochure, manual and PREA video. The Manual is not up to date and has contact information for staff that do not work at the facility. The facility shall update the manual with the correct information. Corrective Action Implemented: The handbook was updated, removing specific names of staff and listing the titles of the positions associated as a point of contact No further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility is in corrective action to address, PREA education, updating manual, and staff access to language line services. The corrective actions were completed and follow-up reviewed confirmed that the corrective actions were implemented. With these measures in place, the initial audit findings are resolved, and the facility is compliant with the provisions of the standard.

115.334	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement

	Setting (2) d. Training Curriculum 2. Interviews: a. Investigative staff - 2 Findings (By Provision): 115.334 (a). In addition to the general training provided to all employees pursuant to § 115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As indicated in the PAQ, the agency/facility does not have trained investigators as all PREA-related investigations are conducted by an outside entity. The agency does not conduct any sexual abuse investigations. While the facility does not conduct investigations, the auditor recommended that a facility staff person complete the specialized training for investigations in the event the administrative component is not addressed by the outside investigator. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway will provide training as needed for staff to conduct administrative investigations” (p. 10). · Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting (2) · Training Curriculum: The agency employs the NIC's "Investigating Sexual Abuse in Confinement Settings" training curriculum. Interviews Investigative Staff: The interviewed staff reported that they received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings. The training included: techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, Sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative or prosecution referral. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility is fully compliant with this provision. 115.334 (b). Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting (2) · Training Curriculum: The agency employs the NIC's "Investigating Sexual Abuse in Confinement Settings" training curriculum. Interviews Investigative staff: The interviewed staff reported that the training included all of the above. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.334 (c). The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains documentation showing that investigators have completed the required training. The number of investigators currently employed who have completed the required training: 1. · Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting (2) Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

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

115.335	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: · Pre-Audit Questionnaire (PAQ) · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual · Certification for Specialized Training PREA 201 for Medical and Mental Health practitioners (14) · Annual PREA Training (18) · Training Curriculum (NIC-PREA 201 Medical and Mental Health Training) Interviews: Medical and Mental Health Staff (1) Findings (By Provision): 115.335 (a). The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:(1) How to detect and assess signs of sexual abuse and sexual harassment;(2) How to preserve physical evidence of sexual abuse;(3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: · The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The number of all medical and mental health care practitioners who work regularly at this facility who received the training required by agency policy: 9. The percentage of all medical and mental health care practitioners who work regularly at this facility received the training required by agency policy. 100. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “All full and part time medical and mental health care practitioners employed by Pathway receive training regarding: a. How to detect and assess signs of sexual abuse and sexual harassment b. How to preserve physical evidence of sexual abuse c. How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment d. How and to whom to report allegations or suspicions of sexual abuse and sexual harassment All full time medical and mental health care practitioners employed by Pathway shall receive training as indicated in the above “Staff Training” section of this Policy Manual” (p. 10). · Certification for: Specialized Training PREA 201 for Medical and Mental Health practitioners (14) · Training Curriculum: The agency employs the NIC's "PREA 201Medical and Mental Health Training" training curriculum. Interviews Medical and Mental Health Staff: The interviewed staff reported that they completed the online training on sexual abuse and sexual harassment. The training included: how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and how and whom to report allegations or suspicions of sexual abuse and sexual harassment. Corrective Action: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.335 (b). If medical staff employed by the agency conduct forensic

	examinations, such medical staff shall receive the appropriate training to conduct such examinations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, agency medical staff at this facility do not conduct forensic medical exams. · The facility does not conduct forensic examinations. Forensic examinations if needed will be conducted at the local child advocacy center. Interviews Medical and Mental Health Staff: The interviewed staff reported that they do not complete forensic medical exams. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.335 (c). The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility maintains training records of the medical and mental health staff. A sample of three medical and mental health staff records were reviewed and confirmed that the staff receives training as required by the standard. · Certification for: Specialized Training PREA 201 for Medical and Mental Health practitioners (14) Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.335 (d). Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.331 or for contractors and volunteers under § 115.332, depending upon the practitioner's status at the agency.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · General PREA Training records: The facility provided in service rosters for three separate training dates where 18 clinical staff received PREA Policy and Procedure training. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.341	**Obtaining information from residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Risk Screening (21) d. Reassessment (11) e. Updated Assessment Tool Instruction f. List of Residents Admitted into Facility Last 12 months 2. Interviews:

a. Staff responsible for risk screening - 1

b. Random sample of residents - 10

c. PREA coordinator

d. PREA compliance manager

3. Corrective Action:

a. Updated Assessment Instructions

b. Additional Risk Assessments (6)/Reassessments (2)

c. Enrollment Information (2)

Findings (By Provision):

115.341 (a). Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident.

Compliance Determination:

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

· As reported in the PAQ, the agency has a process in place to screen and support the residents in care. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The number of residents entering the facility (either through intake of transfer) within the past 12 months whose length of stay in the facility was for 72 hours or more and who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 35.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that:

Pathway clients/residents will be assessed for their risk of being sexually abused by others or sexually abusive toward others. Within 24 hours of intake, clients/residents will be assessed to determine whether they meet specific criteria indicating vulnerability to sexual abuse. Residents may not be disciplined for refusing to answer or failing to disclose information in regard to the assessment questions.

Potential Victim: During initial assessment meeting, residents will be assessed, utilizing an objective screening tool, to specifically determine their vulnerability as indicated by the following risk factors:

Prior sexual victimization or abusiveness;

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; · Current charges and offense history; · Age; · Level of emotional and cognitive development; · Physical size and stature; · Mental illness or mental disabilities; · Intellectual or developmental disabilities; · Physical disabilities; · The client’s own perception of vulnerability; · Whether the client/resident has previously been in a residential facility or incarcerated; · Client/resident has prior convictions for sex offenses against an adult or child · Any other specific information about individual clients that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other clients. A client/resident should be designated with and identified for vulnerability if: · Three or more of the above criteria apply; or · One or more of these factors apply with sufficient documentation by the reviewer to warrant concern. The client’s therapist will reassess each client's/resident's risk of victimization or abusiveness within 30 days after the initial meeting based upon any additional, relevant information received by Pathway since the initial screening. · A client's/resident's risk level will be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the client's/resident's risk of sexual victimization or abusiveness. · To ensure confidentiality and sensitivity of information of the client's/resident's responses on the assessment, assessment information will be kept in the client's/ resident's confidential file. However, communication will be disseminated to staff regarding a client’s overall risk of victimization or risk of perpetrating a violent or sexual act. This will include only the clinician’s assessment of risk, information specific to the client’s history (pp. 11-12). · The auditor reviewed a list of residents admitted into the facility in the last 12 months. Twenty files were randomly selected for review.

	· Records of Residents: The auditor reviewed the Pathway Vulnerability Assessment for 21 residents and it was determined that the facility consistently completes the assessments upon intake. · Records of Residents: The auditor reviewed the Pathway Vulnerability Reassessment for (11) residents who were housed at the facility for at least 30 days. It was determined that the reassessments are not completed on a consistent basis. Site Review PREA Risk Screening Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process. · Staff Responsibilities and Process: o The auditor confirmed that mental health staff are responsible for conducting the PREA risk screening. o The screening takes place in the private office of the mental health staff, ensuring confidentiality. Only the mental health staff is present during the screening, and each housing unit has its own assigned mental health staff member. o During the mock demonstration, the mental health staff asked each question individually, periodically checking the resident’s understanding and repeating responses to ensure accuracy. More specifically the screening staff affirmatively asks the residents about their sexual orientation and gender identity as the questions are presented on the screening instrument. o The screening staff will not only ascertain information on the tool based on resident responses but also use subjective determination on the resident’s perceived status related to sexual orientation and/or gender identity. o The screening staff uses an adjustment instrument that is designed to collect information during the screening process. o Screenings are documented electronically in a secure client file accessible only to clinical staff and the facility director. The mental health staff follow the screening instrument verbatim when asking questions. o Additionally, mental health staff review the client file provided by DYS before placement, which may include information on criminal history, prior placements, psychological background, family history, and trauma history. Informal Conversations: · With Mental Health Staff: o The auditor asked how staff handle situations where a resident's information conflicts with the data provided by DYS. Staff reported that they would rephrase the

question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments.

· With Residents:

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

Interviews

Staff Responsible for Risk Screening – The interviewed staff responsible for performing screening for risk of victimization and abusiveness reported that all residents are screened for risk of sexual abuse victimization or risk of sexually abusiveness toward other residents. The screening occurs immediately upon youth placement at the facility. The information is ascertained through conversations with residents, review of placement packet, and prior history. The information is ascertained by asking questions and reviewing the placement documentation. Prior to a youth's placement at the facility, we have information to review. A reassessment is completed within 30 days.

Residents(s) in custody Interview Questionnaire: Out of the ten residents interviewed while in custody, all of the residents have been placed at the facility within the last year. All of the interviewed residents reported that upon admission, they were asked about prior history of sexual abuse, having any disabilities, whether they identify as being gay, bisexual, or transgender, or whether they think they may be in danger of sexual abuse. Seven of the ten residents reported being asked the same questions again. One resident reported that the counselor asks every month. One of the residents that reported not being asked, was not asked had not been at the facility for more than 30 days.

Corrective Actions:

· The facility policy indicates that the initial reassessment shall be completed within 30 days of the initial assessment. Upon reviewing resident files, it was determined that the practice is not done consistently. The auditor will monitor for a two-month period to ensure that the practice is consistently being conducted.

Due Date: 11/30/2024 (New Intakes in September and October)

Corrective Action Implemented: During the correction phase the facility provided documentation of new intake orientation. There were two youth whose intake date appeared out of range; however, it is because the system was picking up the initial intake date from a prior intake. In addition to the documentation of orientation that was provided (6), reassessment (2) there are two additional documents enrolled to verify the correct intake date. The documentation provided was consistent with the requirements of the provision, no further action required.

	115.341 (b). Such assessments shall be conducted using an objective screening instrument. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The PAQ indicated that the facility utilizes a risk assessment that is an objective screening instrument. · The auditor reviewed the Pathway Vulnerability Assessment and it was determined that the site is using an objective screening instrument. Objectivity was determined based on the following: o Standardized Criteria: It uses pre-determined, clear, and measurable criteria for evaluating risk. o Consistent Application: The instrument is applied uniformly to all individuals being assessed, ensuring that each person is evaluated using the same criteria and process. o Quantifiable Metrics: There is a numerical scoring system with clearly defined categories to measure risk, reducing reliance on personal judgment. o During the post onsite process, updates were made to the tool to clarify areas such as emotional and cognitive development; and intellectual or developmental disabilities. There is an instruction on the tool as to where to appropriately capture said areas. o It should be noted that based on the program description; admission criteria would exclude a resident with an IQ of 62 or below (PATHWAY - Moderate Program (pathway-inc.com). Corrective Actions: · Corrective Action: While the site and the intake staff were aware how to capture emotional and cognitive development; and intellectual or developmental disabilities; the auditor requested that is more clearly indicated on the tool. Corrective Action Implemented: The tool was updated to clearly indicate which sections to capture the information. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.341 (c). At a minimum, the agency shall attempt to ascertain information about: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive

	development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · A review of the screening instrument confirmed that the above-mentioned areas ascertained on the Vulnerability Assessment Tool · The assessment is conducted using an objective screening instrument. The Pathway Vulnerability Assessment ascertains the above information during the intake process. · Resident Records Reviewed (Vulnerability Assessment): 21.The vulnerability assessment ascertained the above-mentioned information. Site Review PREA Risk Screening Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process. · Staff Responsibilities and Process: o The auditor confirmed that mental health staff are responsible for conducting the PREA risk screening. o The screening takes place in the private office of the mental health staff, ensuring confidentiality. Only the mental health staff is present during the screening, and each housing unit has its own assigned mental health staff member. o During the mock demonstration, the mental health staff asked each question individually, periodically checking the resident’s understanding and repeating responses to ensure accuracy. More specifically the screening staff affirmatively asks the residents about their sexual orientation and gender identity as the questions are presented on the screening instrument. o The screening staff will not only ascertain information on the tool based on resident responses but also use subjective determination on the resident’s perceived status related to sexual orientation and/or gender identity. o The screening staff uses an adjustment instrument that is designed to collect information during the screening process. o Screenings are documented electronically in a secure client file accessible only

	to clinical staff and the facility director. The mental health staff follow the screening instrument verbatim when asking questions. o Additionally, mental health staff review the client file provided by DYS before placement, which may include information on criminal history, prior placements, psychological background, family history, and trauma history. Informal Conversations: · With Mental Health Staff: o The auditor asked how staff handle situations where a resident's information conflicts with the data provided by DYS. Staff reported that they would rephrase the question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments. · With Residents: o Residents confirmed that they completed the PREA risk screening on their first day, conducted by the mental health staff in a private office. They reported being asked specific questions during the process. Interviews Staff Responsible for Risk Screening – The interviewed staff responsible for risk screening reported that the initial risk screening considers prior history, vulnerabilities, stature, and prior charges. The information is ascertained through interviews and observation. Corrective Actions: · Corrective Action: While the site and the intake staff were aware how to capture emotional and cognitive development; and intellectual or developmental disabilities; the auditor requested that is more clearly indicated on the tool. Corrective Action Implemented: The tool was updated to clearly indicate which sections to capture the information. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.341 (d). This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: Site Review PREA Risk Screening Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process. · Staff Responsibilities and Process: o The auditor confirmed that mental health staff are responsible for conducting the PREA risk screening. o The screening takes place in the private office of the mental health staff, ensuring confidentiality. Only the mental health staff is present during the screening, and each housing unit has its own assigned mental health staff member. o During the mock demonstration, the mental health staff asked each question individually, periodically checking the resident's understanding and repeating responses to ensure accuracy. More specifically the screening staff affirmatively asks the residents about their sexual orientation and gender identity as the questions are presented on the screening instrument. o The screening staff will not only ascertain information on the tool based on resident responses but also use subjective determination on the resident's perceived status related to sexual orientation and/or gender identity. o The screening staff uses an adjustment instrument that is designed to collect information during the screening process. o Screenings are documented electronically in a secure client file accessible only to clinical staff and the facility director. The mental health staff follow the screening instrument verbatim when asking questions. o Additionally, mental health staff review the client file provided by DYS before placement, which may include information on criminal history, prior placements, psychological background, family history, and trauma history. Informal Conversations: · With Mental Health Staff: o The auditor asked how staff handle situations where a resident's information conflicts with the data provided by DYS. Staff reported that they would rephrase the question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments. · With Residents:

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

Interviews

Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that the information is ascertained by talking to residents and reviewing their charges and referral packet.

Corrective Actions:

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

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

115.341 (e). The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Compliance Determination:

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

Site Review

· Risk Screening Process:

The risk screening is conducted and securely stored in an electronic case management system, accessible only to clinical staff and facility directors. This system also includes other assessment tools, such as the DYS assessment, biopsychosocial evaluations, and treatment plans.

· Access Control:

Informal conversations with mental health and direct care staff confirmed that access to the case management system, particularly to the assessments, is strictly limited to clinical staff and facility leadership.
Additional conversation occurred with the facility director who further reported that there are limitations to who has access to the client case management system.
Interviews

PREA Coordinator – The interviewed PREA Coordinator reported that, therapists and administrative staff have access to this information in their chart.

PREA Compliance Manager- The interviewed staff reported that the information is limited to clinical staff and the Director.

Staff Responsible for Risk Screening - The interviewed staff responsible for risk

	screening reported that the information is only accessible to the clinical staff and higher-level staff. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility is under corrective action to address the completion of the reassessments in a timely manner. The corrective actions were completed, and follow-up was reviewed. With these measures in place, the initial audit findings are resolved and the facility is compliant with the provisions of the standard.

115.342	**Placement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Memo: Determining Group Placement for Residents d. Risk Assessment (21) 2. Interviews: a. PREA compliance manager b. PREA coordinator c. Staff responsible for Risk Screening – 1

d. LGB Resident-1

e. Director

f. Staff who supervise residents in isolation -2

Findings (By Provision):

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

Compliance Determination:

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

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

· Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Screening information shall be used to determine rooming assignments with the goal of keeping separate those clients/residents at high risk of being sexually victimized from those at high risk of being sexually abusive.

Clients/Residents considered high risk for sexual victimization will be placed in room assignments on an individualized basis. Pathway will determine how to best keep residents safe from sexual victimization. Housing decisions in general and specifically housing for more vulnerable clients are determined by the consensus of the Treatment Team.

Pathway shall consider on a case-by-case basis whether a placement of any client would ensure the client's/resident's health and safety, and whether the placement would present management or security problems” (p. 12-13).

· Memo: The facility director provided a memo that stated the below process is used in determining group placement for residents:

Upon admission, residents will typically be placed in the team with an available bed. However, the following factors will be taking into consideration when determining group placement:

· History of victimization

· Gender Identity

· Sexual Orientation

· History of Aggressive Behavior

	· Any previous relationships with other residents outside of Pathway Group placement for transgender and intersex residents will be based on safety, and they will be placed in the group in which they are most likely to be safe. Safety will also be a consideration for other residents identified as vulnerable, including residents whose sexual orientation is not heterosexual. The LGBTI residents will never be placed in separate groups solely due to their sexual orientation or gender identify/expression. When possible, we will not place residents who are familiar with one another in the community in the same group. · Risk Assessment (21) completed. · The facility is a moderate risk site that is designed like community resident program. There are two housing units that can maximum hold eight residents. All residents are placed in a single room that has no doors. The two dorms are programmed and educated separately allowing for no cross populating. Resident records are pre-reviewed along with onsite assessments to determine housing. Programming is limited to each dorm and the residents per dorm are educated separately. Programming onsite can include the following: o Individual Counseling o Medical Services o Group Counseling o Recreational Services o Family Therapy o Basic Living Skills Training o Substance Abuse Treatment o Independent Living Skills Training o Vocational Training o Educational Services o Psychiatric Services The clinician is located on the dorm and provides all services except education and psychiatric services. Vocational services are limited to vocational awareness. Psychiatric services are as needed based on the resident needs and provided by the appropriate medical staff. · Upon intake the clinician conducts the assessment and reviews all

documentation to determine a resident's vulnerability to victimization and sexually aggressive behaviors. Although the rooms are single occupancy if there are any identified concerns the residents will be placed in the most appropriate room or dorm. The auditor observed in review of the investigations that when an allegation was made the facility immediately made adjustments to housing if needed. When asked, the Director reported that if they cannot safely provide services to a resident, they will immediately call DYS to make the necessary arrangements for other placement.

· The clinician's office and the direct care staff staging area sits in between the resident rooms. There are four rooms on each side, with the middle of the building serving as a common area.

· There is a treatment team that meets to review all new intakes along with ongoing meetings.

Interviews

PREA Compliance Manager – The interviewed staff reported that the information from the risk screening during intake is used to determine the best fit dorm. When assigned into a dorm, we do not cross populate dorms. Residents in the same dorm go to school and program together. We will receive information prior to intake on the residents through the referral process. We will also include and review prior history, prior to resident placement.

Staff Responsible for Risk Screening – The interviewed staff reported that the agency/facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment. The information is used for housing and ensuring that the youth are safe. The information is given to the leadership to make housing decisions.

Corrective Actions:

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

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

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

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard

	because: · As stated in the PAQ, the facility has a policy that indicates that the residents at risk of sexual victimization will only be placed in isolation if less restrictive measures are inadequate to keeping them and other residents safe. The facility policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. The number of residents at risk of sexual victimization who were placed in isolation in the past 12 months: 0 The number of residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education or special education services in the past 12 months: 0 The average period of time residents at risk of sexual victimization were held in isolation to protect them from sexual victimization in the past 12 months: 0 · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that the “Isolation will be used only as a last resort when less restrictive measures are inadequate to keep them and other clients safe, and then only until an alternative means of keeping all clients safe can be arranged. During any period of isolation, clients shall not be denied daily large-muscle exercise, educational programming, or special education services. Clients in isolation shall have access to other programs and work opportunities to the extent possible, not to exceed the same access afforded to clients not in isolation. Clients in isolation shall receive daily visits from a medical or mental health care clinician. If a client is isolated, Pathway staff shall clearly document: o The basis for concern for the client’s safety o The reason no alternative means of separation can be arranged. o If isolation lasts longer than 30 days, Pathway shall afford each client a review to determine whether there is a continuing need for separation from the general population.” (p. 13). · There no residents placed in isolation therefore there are no documents to review. Upon review of the area where isolation could be used, it is more a separation room, as the resident would be behind a closed door with a large window forward facing the hallway. Staff indicated that they have never used the room, but if so, it would be used as a temporary cool off. The set up of the facility is moderate security level and the overall layout does not allow for a resident to be completely isolated if the more secure room is utilized. Interviews Director: The interviewed director reported that they have not had any instances of isolation due to sexual abuse allegation. Isolation would be used as a last resort. If the juvenile asks for isolation or alone time. The site does not have any true isolation rooms. For the cool off a resident would be placed on a 1:1 ratio to protect

	themselves. Medical and Mental Health Staff – We do not use isolation; however, we have a cool off room on a unit. It has not been used to often. If they are in there, they may be in there for only 10 minutes. We are housed on the unit and will still meet with them if in the cool off room. Part of the process is to meet with them and regulate them. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.342 (c). Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility prohibits placing lesbian, gay, bisexual, or intersex residents in particular housing, bed, or other assignments solely based on such identification status. The PAQ further reiterates that the facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway does not place gay, bisexual, transgender or intersex clients/residents in dedicated facilities, rooms or floors solely on the basis of such identification” (p. 13). · There were no residents identified as lesbian, gay, bisexual, transgender, or intersex; therefore, there were no housing assignments to review related to the provision. However, it should be noted that the facility consists of two hosing units, with eight residents per unit. Interviews PREA Coordinator - The interviewed PREA Coordinator reported that the facility does not have a special housing unit for lesbian, gay, bisexual, transgender, or intersex residents. PREA Compliance Manager – The interviewed staff reported that the facility does not have specialized housing units for lesbian, gay, bisexual, transgender, or intersex residents.

	Gay, Lesbian, and bisexual resident(s) in custody: There were no identified residents during the onsite audit that were gay, lesbian, or bisexual. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.342 (d). In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility makes housing and facility assignments for transgender or intersex residents in a facility on a case-by-case basis. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: Pathway shall consider on a case-by-case basis whether a placement of any client would ensure the client's/resident's health and safety, and whether the placement would present management or security problems. A transgender or intersex resident's own view with respect to his own safety shall be given serious consideration. Transgender clients/residents will be housed in the safest location as determined by the PREA Compliance Manager, PREA Coordinator and client/resident’s therapist. Placement and programming for each transgender or intersex client shall be reassessed at least twice yearly to review any threats to safety experienced by the client (pp. 8-9). Interviews PREA Compliance Manager – The interviewed staff reported that room assignments are determined based on the resident’s safety. We will assess vulnerability, review the make-up of the campus and location to determine safety. We do not have a lot of options, so we would assess to see which dorm is the best fit. Transgender/Intersex Residents: There were no identified transgender or intersex residents during the onsite review. Corrective Actions: N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.342 (e). Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · There were no identified transgender or intersex residents; therefore, there was no documentation of reassessment to review. Interviews PREA Compliance Manager – The interviewed staff reported that room assignments are determined based on the resident’s safety. Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that all residents are given the opportunity to shower separately from other residents. Safety is given serious consideration in placement and programming assignment of transgender or intersex residents. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.342 (f). Transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews PREA Compliance Manager – The interviewed staff reported that room assignments are determined based on the resident’s safety. Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that transgender and intersex are residents given the opportunity to shower separately from other residents. It was further reported that all residents shower separately. All residents shower separately. Transgender/Intersex Residents: There were no identified transgender or intersex residents during the onsite review.

Corrective Actions:

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

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

115.342 (g). Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Compliance Determination:

Interviews

PREA Compliance Manager - Placement and programming assignments for each transgender or intersex resident is reviewed at least every six months. We have not had it happen yet, but this is the process.

Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, they will coordinate with the director to determine necessary treatment services. This would occur immediately.

Transgender/Intersex Residents: There were no identified transgender or intersex residents during the onsite review.

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

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

115.342 (h). If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: (1) The basis for the facility's concern for the resident's safety; and (2) The reason no alternative means of separation can be arranged.

Compliance Determination:

· The PAQ indicated that there were zero residents at risk of sexual victimization who were held in isolation in the past 12 months.

· Upon review of the process and a room that can be used for isolation it does not appear that the site has a formal isolation process, more of a cool off area, as the resident would not be separated from other residents unless there were no other residents on the housing area. The overall set up of the facility and its security level is moderate. If a resident is placed in the room, its designed more in alignment with a less restrictive environment without the use of isolation.

· There were no residents identified as ever being placed in the “isolation” room and through informal conversation with residents the room has never been

	occupied during the placement at the facility. N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.342 (i). Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population. Compliance Determination: · As reported in a PAQ if a resident at risk of sexual victimization is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that Isolation will be used only as a last resort when less restrictive measures are inadequate to keep them and other clients safe, and then only until an alternative means of keeping all clients safe can be arranged. During any period of isolation, clients shall not be denied daily large-muscle exercise, educational programming, or special education services. Clients in isolation shall have access to other programs and work opportunities to the extent possible, not to exceed the same access afforded to clients not in isolation. Clients in isolation shall receive daily visits from a medical or mental health care clinician. If a client is isolated, Pathway staff shall clearly document: The basis for concern for the client's safety The reason no alternative means of separation can be arranged. If isolation lasts longer than 30 days, Pathway shall afford each client a review to determine whether there is a continuing need for separation from the general population (p. 13). Interviews: Staff who Supervise Residents in Isolation – All direct care staff at the facility can supervise a resident in isolation. The staff reported that they have never had to use the process, but if so, it is a temporary limited time process that they would use to regain control of the resident. The interviewed staff further reported that they would have to involve the Director. The residents would not be in isolation long enough to be restricted from any service. The clinician is housed on the unit and medical staff will come to the unit as needed to render services to any resident. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – During the onsite audit and upon file review there were no residents held in isolation. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.351	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Pathway Staff Handbook d. Resident Handbook e. Grievance Form (English/Spanish) f. 12 Month Grievance Logbook g. DYS Grievance Policy h. Investigations (3) 2. Interviews: a. Random sample of staff - 8 b. Random sample of residents - 10 c. PREA compliance manager 3. Corrective Action: a. Pictures of Grievance Box (2)

b. Handbook Updated

Findings (By Provision):

115.351 (a). The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

Compliance Determination:

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

· As reported in the PAQ, the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: • sexual abuse and sexual harassment; • retaliation by other residents or staff for reporting sexual abuse and sexual harassment; AND • staff neglect or violation of responsibilities that may have contributed to such incidents.

· Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway maintains multiple ways for clients/residents and staff to report allegations of sexual abuse/harassment/staff sexual misconduct perpetrated by other clients/residents, staff contractors or volunteers, retaliation by other clients/residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Pathway staff are mandated to accept all reports of abuse. Upon program entry, clients/residents are informed of ways they can report sexual abuse. These include verbal and/or written reports to any facility staff or the agency PREA Compliance Manger. Reports can also be made anonymously and from third parties. Additionally, clients/residents are informed they may also contact local sexual abuse resources” (p. 14).

· Grievance Form: The grievance forms utilized by the agency are the grievance process used by DYS. The DYS has an advocacy program where an advocate comes out weekly to review the grievances in the grievance box and discuss the grievances with the residents. Furthermore, the DYS Grievance policy states that if the grievance alleges sexual abuse will immediately notify the DYS chief advocate, through the chain of command, who will notify investigations.

· The facility does not have a formal grievance process. The residents are allowed to complete a form and give it to a supervisor or the mental health worker.

· Resident Handbook states:

If you need to report sexual harassment, sexual abuse, staff sexual misconduct, retaliation by other clients or staff members for reporting sexual abuse/harassment/ misconduct, or staff neglect that may have contributed to any of the above incidents, you can use the following reporting methods:

	· Make a written report by completing a Grievance Form, which can be turned into to the PREA Compliance Manager/Program Director · Make a verbal report by asking to speak with your therapist, the shift leader on duty, or the PREA Compliance Manager/Program Director · Make a written or verbal report to any staff member that you trust (Group leader, Teacher, Nurse, Food Service Staff, etc.) · Ask to call the Rape Crisis Hotline · Report anonymously to Pathway by completing a Grievance Form without signing the form and placing the form in the locked Grievance Box · Report anonymously to a third party by writing a letter/filling out an unsigned grievance form and placing it in a pre-addressed/stamped envelope that will be provided to you at intake. You can place this envelop in the locked Grievance Box If you have experienced sexual abuse or sexual harassment at Pathway, we will provide you with access to a victim advocate from the Child Advocacy Center upon request who will provide emotional support services throughout the investigative process. To request access to a victim advocate, speak with your therapist or make a written request to your therapist, the PREA Compliance Manager (Mrs. Grace), or the PREA Coordinator (Mrs. Kimmy) (p. 9). Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: Initially, the signage was too complex for the average resident. However, it has been updated to a middle school reading level for better understanding. Signage about emotional and victim advocacy support services was not available at first. During the review, the site added new signage detailing these services and how to access them by phone or mail. Signage is available in both English and Spanish. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. The agency site contact information needed to be updated. Placement:

	Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It should be noted that staff reported that they could anonymously report using the grievance box as well. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. Testing Internal Reporting Methods for Confined Persons · Internal Reporting: o The auditor evaluated the internal reporting methods by contacting the phone numbers listed on the facility's posters. It was confirmed that residents can call the hotline to make a report, and if an allegation is made, the Department of Youth Services (DYS) will notify the facility to initiate an investigation. Calls made to the national hotline are redirected to the state DYS. · Written Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. Each housing unit has a DYS grievance box with forms available in both English and Spanish, ensuring residents have easy daily access to submit grievances. o Informal conversations with residents confirmed that they have access to writing materials and can either place their grievance in the box or submit a written statement under the door of the mental health staff. · Electronic Reporting: o The facility does not currently offer electronic means for residents to report allegations of sexual abuse or harassment. · Verbal Reporting: o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member or the DYS advocate, and they feel comfortable approaching trusted staff privately. o Staff consistently reported that residents can verbally report allegations at any time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay. Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom) · Outgoing Mail:

	o The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows: § Residents write a letter, place it in an envelope obtained from the mental health staff, who then deliver it to administrative staff. § Administrative staff verify that the letter is addressed to an approved authority. § The mail clerk confirmed that resident mail is not read before being sent. They simply place a stamp on the envelope and ensure the mail is sent. · Incoming Mail: o Incoming mail follows a similar process. The mail clerk verifies that it is from an approved party, and residents open their mail in front of staff, shaking the envelope to ensure nothing is concealed. o While the facility does not have a locked or secured mail drop box, all incoming and outgoing mail is logged, which the auditor observed. Mail access is managed by the mental health staff and the mail clerk. Record Storage · Risk Screening Process: o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected. · Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only. Interviews Random Sample of Staff - The interviewed staff reported various ways in which they could privately report sexual abuse or sexual harassment of residents. Such methods include calling the PREA Director, hotline number, supervisor, or grievance box. Residents(s) in custody Interview Questionnaire: The interviewed residents reported various methods to report sexual abuse or sexual harassment that happened to them or someone else by notify staff, write a letter, call the hotline, grievance, notify the PREA officer, or tell their family. DYS Advocate: The auditor conducted an informal interview with a DYS advocate. The advocate provided the auditor with the process used to review the grievances, meet with the youth and if there is a PREA related grievance they would

	immediately report the incident to the site leadership. Corrective Actions: · The auditor observed that the grievance box in one unit was on a table, having come off the wall, while in another unit, the grievance box was hanging by just one screw. Although the boxes are locked, the facility should ensure that they are securely attached to the wall in both units. Corrective Action Implemented: Two pictures of the grievance boxes were provided showing that the boxes were fixed and appropriately secured on the walls. · The facility provides information at intake through the PREA brochure, handbook and PREA video. The Manual is not up to date and has contact information for staff that do not work at the facility. The facility shall update the manual with the correct information. Corrective Action Implemented: The handbook was updated, removing specific names of staff and listing the titles of the positions associated as a point of contact No further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.351 (b). The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides more than one way for residents to report abuse or harassment to a public or private entity that is not part of the agency. The PAQ further states that the agency does not detain for civil immigration purposes. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway maintains multiple ways for clients/residents and staff to report allegations of sexual abuse/harassment/staff sexual misconduct perpetrated by other clients/residents, staff contractors or volunteers, retaliation by other clients/residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Pathway staff are mandated to accept all reports of abuse. Upon program entry, clients/residents are informed of ways they can report sexual abuse. These

include verbal and/or written reports to any facility staff or the agency PREA Compliance Manger. Reports can also be made anonymously and from third parties. Additionally, clients/residents are informed they may also contact local sexual abuse resources" (p. 14).

· Grievance Form: The grievance forms utilized by the agency are the grievance process used by DYS. The DYS has an advocacy program where an advocate comes out weekly to review the grievances in the grievance box and discuss the grievances with the residents. Furthermore, the DYS Grievance policy states that if the grievance alleges sexual abuse will immediately notify the DYS chief advocate, through the chain of command, who will notify investigations.

· Resident Handbook

If you need to report sexual harassment, sexual abuse, staff sexual misconduct, retaliation by other clients or staff members for reporting sexual abuse/harassment/ misconduct, or staff neglect that may have contributed to any of the above incidents, you can use the following reporting methods:

· Make a written report by completing a Grievance Form, which can be turned into to the PREA Compliance Manager/Program Director

· Make a verbal report by asking to speak with your therapist, the shift leader on duty, or the PREA Compliance Manager/Program Director

· Make a written or verbal report to any staff member that you trust (Group leader, Teacher, Nurse, Food Service Staff, etc.)

· Ask to call the Rape Crisis Hotline

· Report anonymously to Pathway by completing a Grievance Form without signing the form and placing the form in the locked Grievance Box

· Report anonymously to a third party by writing a letter/filling out an unsigned grievance form and placing it in a pre-addressed/stamped envelope that will be provided to you at intake. You can place this envelop in the locked Grievance Box

If you have experienced sexual abuse or sexual harassment at Pathway, we will provide you with access to a victim advocate from the Child Advocacy Center upon request who will provide emotional support services throughout the investigative process. To request access to a victim advocate, speak with your therapist or make a written request to your therapist, the PREA Compliance Manager (Mrs. Grace), or the PREA Coordinator (Mrs. Kimmy) (p. 9).

During the site review, the auditor noted the following:

Signage Clarity and Accessibility:
Initially, the signage was too complex for the average resident. However, it has been updated to a middle school reading level for better understanding.
Signage about emotional and victim advocacy support services was not available at

first. During the review, the site added new signage detailing these services and how to access them by phone or mail.
Signage is available in both English and Spanish.
The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake.
Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced.
The signage contained information on how to make a report and who to make a report
Accuracy and Consistency:
The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. The agency site contact information needed to be updated.
Placement:
Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas.
Informal Conversations:

With Staff and Residents:
Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents.
It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services.
Reporting via Phone:

· Phone Access:

Residents do not have unrestricted access to a phone. Instead, they must request permission from mental health staff to use the phone for external reporting.
· Auditor's Test:

The auditor evaluated the external reporting method by calling the listed hotline as a resident would. The test confirmed the following:
The staff phone that residents use to make a report is functional.
The phone number on the signage connects directly to the external reporting entity.
Reporting does not require the resident to provide their name; however, they must request phone access through staff, typically mental health staff.
The hotline number is local/toll-free, answered by a live person, and available 24/7.
The external reporting entity is equipped to receive reports of sexual abuse and harassment from residents and promptly forwards reports to agency officials. During the test, the auditor spoke with a representative who confirmed that residents can make reports and that the facility would be notified if pertinent information is provided.
The reporting entity also confirmed that residents can report anonymously upon

request.

· Phone Call Privacy:

While residents can access a phone through staff, informal conversations with staff indicated that when a resident requests to call the hotline, staff allow for confidentiality by stepping away, though they maintain a line of sight for supervision. Mental health staff also stated that accommodations are available for residents who are limited English proficient or have disabilities.

· Monitoring of Other Calls:

Calls to parents and individuals on the approved list are monitored.
Informal conversations with staff confirmed that phone calls are monitored to ensure compliance with the approved contact list. However, if a resident requests to call the hotline, staff will dial the number and then provide some privacy by stepping away while maintaining visual supervision.
Residents, during informal conversations, reported that while calls are generally monitored, they believe they could have a confidential conversation if needed.
Testing Internal Reporting Methods for Confined Persons

Written Reporting:

o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. Each housing unit has a DYS grievance box with forms available in both English and Spanish, ensuring residents have easy daily access to submit grievances.

o Informal conversations with residents confirmed that they have access to writing materials and can either place their grievance in the box or submit a written statement under the door of the mental health staff.

Electronic Reporting:

o The facility does not currently offer electronic means for residents to report allegations of sexual abuse or harassment.

Verbal Reporting:

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

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

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

o Outgoing Mail:

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

	o Residents write a letter, place it in an envelope obtained from the mental health staff, who then deliver it to administrative staff. o Administrative staff verify that the letter is addressed to an approved authority. o The mail clerk confirmed that resident mail is not read before being sent. They simply place a stamp on the envelope and ensure the mail is sent. o Incoming Mail: o Incoming mail follows a similar process. The mail clerk verifies that it is from an approved party, and residents open their mail in front of staff, shaking the envelope to ensure nothing is concealed. o While the facility does not have a locked or secured mail drop box, all incoming and outgoing mail is logged, which the auditor observed. Mail access is managed by the mental health staff and the mail clerk. Record Storage Risk Screening Process: o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected. Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only. Interviews PREA Compliance Manager – The interviewed staff reported that phone numbers are provided to DYS and there is a national line that can be used to make reports. The therapist will have to coordinate calls. Residents(s) in custody Interview Questionnaire: All of the interviewed residents could identify at least one person outside of the facility to whom they could report sexual abuse or sexual harassment. The various methods include calling the hotline, telling the DYS advocate, or probation officer. Six of the ten residents further reported that they could make a report without giving their name. The various ways were written a grievance without putting your name on it or call the hotline Corrective Actions: · The auditor observed that the grievance box in one unit was on a table, having come off the wall, while in another unit, the grievance box was hanging by just one screw. Although the boxes are locked, the facility should ensure that they are

	securely attached to the wall in both units. Corrective Action Implemented: Two pictures of the grievance boxes were provided showing that the boxes were fixed and appropriately secured on the walls. · The facility provides information at intake through the PREA brochure, handbook and PREA video. The Manual is not up to date and has contact information for staff that do not work at the facility. The facility shall update the manual with the correct information. Corrective Action Implemented: The handbook was updated, removing specific names of staff and listing the titles of the positions associated as a point of contact No further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.351 (c). Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ, that there is a policy mandating staff to accept reports of sexual abuse or sexual harassment made verbally, in writing, anonymously and from third parties. It further reported that staff are required to document verbal reports within 48 hours. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Clients/Residents are provided reasonable and confidential access to their attorneys, other legal representation, and their parents/legal guardians” (p. 16). · PREA Investigations: The auditor reviewed the investigations and it was determined that allegations were documented. Interviews Random Sample of Staff - The interviewed staff report that when a resident alleges sexual abuse, they can do so verbally, in writing, anonymously and from third parties. They further reported that such allegations would be documented immediately. The staff were able to further describe that residents could verbally tell staff, family, or anyone they trust; they could use the same process to write a letter. The staff reported that anyone could make a report for them and anonymously they could write a grievance. Residents(s) in custody Interview Questionnaire: The interviewed residents reported that they can make a report of sexual abuse or sexual harassment either in person or in writing by notifying family or their PO. The residents felt they could tell any

	trusted staff, DYS worker or call the hotline; write a written grievance or have their family report for them. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.351 (d). The facility shall provide residents with access to tools necessary to make a written report. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. · Grievance Form: The grievance forms utilized by the agency are the grievance process used by DYS. The DYS has an advocacy program where an advocate comes out weekly to review the grievances in the grievance box and discuss the grievances with the residents. · The facility does not have a formal grievance process. The residents are allowed to complete a form and give it to a supervisor or the mental health worker. · PREA Audit Site Review: The auditor observed a locked grievance box in the resident housing area. There were readily available grievance forms for the youth to access. Interviews PREA Compliance Manager: The interviewed staff reported that grievance forms and DYS advocates will come and speak to them as well. The residents can use the phone but they would have to go through the therapist. Corrective Actions: · Grievance Box: The auditor observed that the grievance box in one unit was on a table, having come off the wall, while in another unit, the grievance box was hanging by just one screw. Although the boxes are locked, the facility should ensure that they are securely attached to the wall in both units. Corrective Action Implemented: Two pictures of the grievance boxes were provided showing that the boxes were fixed and appropriately secured on the walls.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.351 (e). The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their response to the Pre-Audit Questionnaire that the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that, “When a client/resident reports an incident of sexual abuse, sexual solicitation, sexual harassment or sexual coercion to Pathway staff members, or staff members observe such incidents, staff will, except as noted elsewhere in agency policy, contact the PREA Compliance Manager and PREA Coordinator. Staff may privately report allegations to the PREA Compliance Manager, PREA Coordinator, or Chief Executive Officer” (pp. 4-5). · Furthermore, the employee handbook states that “Any staff shall immediately report to a senior staff or director, any knowledge, suspicion, or information they receive regarding an incident of sexual abuse, sexual harassment or retaliation that is alleged to have occurred. All staff shall report immediately, within their duty shift, any staff neglect or violation of responsibilities that may have contributed to a sexual assault incident or retaliation. Staff may privately report allegations to the PREA Compliance Manager, PREA Coordinator, or Chief Executive Officer. Juveniles can report allegations of sexual abuse and sexual harassment to staff, a private entity or third party” (p. 17). Interviews Random Sample of Staff - The interviewed staff report that when a resident alleges sexual abuse, they can do so verbally, in writing, anonymously and from third parties. They further reported that such allegations would be documented immediately. The staff were able to further describe that residents could verbally tell staff, family, or anyone they trust; they could use the same process to write a letter. The staff reported that anyone could make a report for them and anonymously they could write a grievance. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

	Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility is in corrective action to update the resident handbook. The corrective actions were completed and follow up reviewed confirmed that the handbook was updated. With these measures in place, the initial audit findings are resolved, and the facility is compliant with the provisions of the standard.

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Grievances Reviewed (12 months) a. Grievance Form (English/Spanish) b. DYS Grievance Policy 2. Interviews: a. DYS Advocate 3. Corrective Action: a. Picture of Grievance Box (2) Findings (By Provision): 115.352 (a). An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ, the agency does not have an administrative process for dealing with resident grievances regarding sexual abuse and is not exempt from this standard. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual provides guidance on the process for residents to file a grievance. OFFICIAL RESPONSE FOLLOWING A CLIENT/RESIDENT REPORT/COORDINATED RESPONSE-Should a client/resident report a sexual abuse/assault by another client/ resident or staff, the following protocol should be followed: Staff shall immediately separate the alleged victim and abuser. The alleged victim may be placed in isolation to keep them safe from the alleged abuser only as a last resort if less restrictive measures are inadequate to keep them and other clients/residents safe and only until an alternative means of keeping all clients/residents safe can be arranged. Pathway will follow all requirements related to isolation (see Section IV, number 13). Staff shall preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. If the report is made immediately following the abuse/assault and the victim has not showered, the victim shall remain in the accompaniment of staff and be instructed not to shower or change clothes, brush their teeth, etc. Ensure the alleged abuser does not take any actions that could destroy physical evidence as appropriate (washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, and eating). The staff shall immediately contact 911 for police and ambulance to respond if the victim needs medical attention. Staff is to request a police officer from the sexual abuse/assault unit. PREA Compliance Manager shall promptly report the allegation to the Department of Human Resources as well as the client’s legal guardian, unless Pathway has official documentation showing the legal guardian should not be notified. After hours, the staff on duty shall contact the PREA Compliance Manager and PREA Coordinator for additional instructions and support (may need additional staff to report to facility). During business hours, the PREA Compliance Manager or designee shall be contacted as soon as possible. The PREA Compliance Manager will be responsible for notifying the PREA Coordinator, who will notify the Chief Executive Officer as appropriate. The PREA Compliance Manager or designee will contact the referring agency and inform them of the situation. In cooperation with the local authorities, Pathway will determine the status of the accused. If the accused is not immediately taken into custody, Pathway management will evaluate and determine if the accused will be

	removed/terminated from the treatment program. Staff are to secure the area where the abuse took place, restricting it from client and staff access until the area is released by the police responding to the incident. Staff should attempt to obtain a written statement from the victim. Staff will also prepare a written report detailing what the client/resident reported to the staff member, additional information regarding observed evidence, actions taken, etc. At any time, the client/resident victim may refuse to participate in the process and not proceed with the investigation/reporting. The client/resident shall not be punished for refusing to cooperate with the investigation. Pathway will work with community resources and the client/resident to ensure that communications with community resources/advocates are confidential to the extent allowable by law. Prior to referral to a community resource, Pathway will inform client/resident of the extent to which client/resident may expect such communications to remain confidential. The client/resident may also report a sexual abuse/assault through a grievance form at any time, regardless of the time frame in which the alleged incident occurred. The client/resident shall be separated from the accused and the victim shall be encouraged to report the incident to the police and receive medical attention/ evaluation. The same attention and services will be offered to a client/resident who reports sexual abuse days or weeks after the alleged abuse. All allegations of sexual abuse/assault shall be taken seriously by staff, recognized as traumatic to the client/resident victim and staff shall be sensitive at all times to the needs and emotions of the victim. Confidentiality and client/resident privacy shall be maintained at all times, with only those who have a direct "need to know" having access to the personal information and details of the victim and alleged perpetrator. If a client/resident does not believe their accusations of sexual abuse/assault were responded to appropriately, they do not feel safe as a result of the abuse, or any other concerns regarding the alleged abuse, they may submit a written grievance following the grievance chain of command up to the agency Chief Executive Officer. The decision and response of the agency Chief Executive Officer is final. As the needs of the client/resident victim are being met, the agency shall assemble the Sexual Abuse Response Team (SART), which may include: the client/resident's Therapist, Senior Shift Leader Supervisor, PREA Compliance Manager, PREA Coordinator, Director, and Chief Executive Officer. · The SART will ensure that the clients are safe, and the victim is being cared for physically and emotionally. · The SART will ensure that policies and procedures are followed.

	· The SART will review the incident and evaluate what possible warning signs were missing. If anything could have been done to prevent the abuse, a corrective action plan will be implemented to prevent an abuse from happening again in the same manner/location, etc. · SART will ensure that the referring agencies are kept informed, and information is relayed between appropriate parties. · The SART will assist in monitoring for potential retaliation. · The SART will maintain investigative records of alleged sexual abuse or harassment as long as the alleged abuser is incarcerated or employed by Pathway plus five years. If an allegation that is reported to and investigated by the appropriate legal authority does not result in criminal charges or disciplinary actions from that body, Pathway reserves the right to conduct an internal investigation. This investigation seeks to determine risk that the abuse/misconduct occurred and will provide Pathway with the opportunity to take the appropriate actions according to agency policy. Incident reports, investigations and results on client/resident sexual abuse/ misconduct will be retained for seven years; statistical data on sexual abuse/assault will be retained for ten years (pp. 17-19). · Grievance Form: The grievance forms utilized by the agency are the grievance process used by DYS. The DYS has an advocacy program where an advocate comes out weekly to review the grievances in the grievance box and discuss the grievances with the residents. Furthermore, the DYS Grievance policy states that if the grievance alleges sexual abuse will immediately notify the DYS chief advocate, through the chain of command, who will notify investigations. Interviews: DYS Advocate: The auditor conducted an informal interview with a DYS advocate. The advocate provided the auditor with the process used to review the grievances, meet with the youth and if there is a PREA related grievance they would immediately report the incident to the site leadership. Corrective Actions: · The auditor observed that the grievance box in one unit was on a table, having come off the wall, while in another unit, the grievance box was hanging by just one screw. Although the boxes are locked, the facility should ensure that they are securely attached to the wall in both units. Corrective Action Implemented: Two pictures of the grievance boxes were provided showing that the boxes were fixed and appropriately secured on the walls. Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility is fully compliant with this provision. 115.352 (b). (1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse. (3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse. (4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. The PAQ further states that agency policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: “The client/resident may also report a sexual abuse/assault through a grievance form at any time, regardless of the time frame in which the alleged incident occurred. The client/resident shall be separated from the accused and the victim shall be encouraged to report the incident to the police and receive medical attention/evaluation. The same attention and services will be offered to a client/ resident who reports sexual abuse days or weeks after the alleged abuse” (p. 18). · 12-month grievances (reviewed onsite) · Blank Grievance Form (English/Spanish) · Grievance Form: The grievance forms utilized by the agency are the grievance process used by DYS. The DYS has an advocacy program where an advocate comes out weekly to review the grievances in the grievance box and discuss the grievances with the residents. · The DYS Policy further states that “no time limit exists when a youth may submit Grievance regarding an allegation of Sexual Abuse” (p. 8). · The facility does not have a formal grievance process. The residents are allowed to complete a form and give it to a supervisor or the mental health worker. Corrective Actions: · The auditor observed that the grievance box in one unit was on a table, having come off the wall, while in another unit, the grievance box was hanging by

	just one screw. Although the boxes are locked, the facility should ensure that they are securely attached to the wall in both units. Corrective Action Implemented: Two pictures of the grievance boxes were provided showing that the boxes were fixed and appropriately secured on the walls. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.352 (c). The agency shall ensure that (1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency reported in the PAQ that the agency's policy and procedure allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Clients/residents are provided access to tools to make written reports of any form of abuse, sexual harassment, retaliation by another client or staff member, and staff neglect or violation of responsibilities. These reports/grievances can be given to any staff member at any time and shall not under any circumstances be submitted to the staff member who is the subject of the complaint” (p. 15). · 12-month grievances (reviewed onsite there were non PREA related) · Grievance Form: The grievance forms utilized by the agency are the grievance process used by DYS. The DYS has an advocacy program where an advocate comes out weekly to review the grievances in the grievance box and discuss the grievances with the residents. The DYS Policy further states that “no youth is required to use any informal Grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse” (p. 8). · The facility does not have a formal grievance process. The residents are allowed to complete a form and give it to a supervisor or the mental health worker. Corrective Actions: · The auditor observed that the grievance box in one unit was on a table, having come off the wall, while in another unit, the grievance box was hanging by just one screw. Although the boxes are locked, the facility should ensure that they are securely attached to the wall in both units. Corrective Action Implemented: Two pictures of the grievance boxes were provided

showing that the boxes were fixed and appropriately secured on the walls.

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

115.352 (d). (1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance. (2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal. (3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made. (4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.

Compliance Determination:

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

· As reported in the PAQ, the agency's policy and procedures require that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. In the past 12 months, the number of grievances that were filed that alleged sexual abuse: 0. In the past 12 months, the number of grievances alleging sexual abuse reached final decision within 90 days after being filed: 0. In the past 12 months, the number of grievances alleging sexual abuse involved extensions because final decision was not reached within 90 days: 0. The agency always notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “A decision regarding the merits of any grievance or portion of a grievance alleging sexual harassment must be made within 90 days of the filling of the grievance. Regarding allegations of sexual abuse, Pathway will make an effort to encourage the investigating agency to ensure a decision is made regarding the merits of the grievance or portion of the grievance within 90 days” (p. 22).

· The DYS Policy further confirms the above requirements in that it states that “a final decision on the merits of any portion of a Grievance alleging Sexual Abuse comes within 90 days of the initial filling of the Grievance”. “Computation of the time period excludes time utilized by Youth in preparing any administrative appeal” (p. 8).

Interviews:

	Residents who Reported a Sexual Abuse: There were no identified residents during the last 12 months nor onsite during the onsite audit process who reported sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.352 (e). (1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. (2) If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process. (3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision. (4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that the agency policy and procedure permit third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. The number of the grievances alleging sexual abuse filed by residents in the past 12 months in which the resident declined third-party assistance, containing documentation of the resident's decision to decline: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: Pathway permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist clients/residents in filing requests for administrative remedies relating to allegations of sexual abuse, and file such requests on behalf of clients/residents. Clients are encouraged to report any act of sexual abuse or sexual harassment that they have witnessed or suspect.

	Third Party Reports from staff are required if they witness or suspect potential sexual abuse or sexual harassment in congruence with Pathway's no tolerance policy. If a client declines to have third-party assistance in filing a grievance alleging sexual abuse, Pathway documents the client's/resident's decision to decline. Pathway allows parents or legal guardians of clients/residents to file a grievance alleging sexual abuse, including appeals, on behalf of such client/resident, regardless of whether or not the client/resident agrees to having the grievance filed on their behalf. Clients/Residents are provided reasonable and confidential access to their attorneys, other legal representation, and their parents/legal guardians (p. 16). · The DYS policy further confirms the above in that third parties, including fellow youth, staff members, family members, attorneys, and outside advocates are permitted to assist residents in filling grievances that allege sexual abuse (p. 8). · 12-month grievances (reviewed onsite) Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: Initially, the signage was too complex for the average resident. However, it has been updated to a middle school reading level for better understanding. Signage about emotional and victim advocacy support services was not available at first. During the review, the site added new signage detailing these services and how to access them by phone or mail. Signage is available in both English and Spanish. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. The agency site contact information needed to be updated. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations:

	With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. Testing Third-Party Reporting Testing the Third-Party Reporting Method: The auditor evaluated the third-party reporting process using the method publicly available, such as through the agency or facility website. The method for third-party reporting posted on the website was confirmed to be easily accessible and understandable, and it is prominently featured on the agency's PREA site. A test report was submitted by the auditor, and an immediate response was received from the facility indicating that follow-up contact would be made regarding the report. The auditor received follow-up correspondence from the PREA coordinator confirming that the report had been acknowledged. Evidence was provided via email showing that the report was received by the facility. Corrective Actions: · The facility provides information at intake through the PREA brochure, handbook and PREA video. The Manual is not up to date and has contact information for staff that do not work at the facility. The facility shall update the manual with the correct information. Due Date: 11/1/2024 Corrective Action Implemented: The handbook was updated, removing specific names of staff and listing the titles of the positions associated as a point of contact No further action needed. 115.352 (f). 1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

because:

· The agency reported in the PAQ that the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. The agency's policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within 5 days. The number of emergency grievances alleging substantial risk of imminent sexual abuse that were filed in the past 12 months:0. The number of those grievances in 115.352(f)-3, that had an initial response within 48 hours: 0. The number of the grievances alleging substantial risk of imminent sexual abuse filed in the past 12 months that reached final decisions within 5 days: 0

Corrective Actions:

· The auditor observed that the grievance box in one unit was on a table, having come off the wall, while in another unit, the grievance box was hanging by just one screw. Although the boxes are locked, the facility should ensure that they are securely attached to the wall in both units.

Corrective Action Implemented: Two pictures of the grievance boxes were provided showing that the boxes were fixed and appropriately secured on the walls.

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

115.352 (g). The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

Compliance Determination:

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

· As reported in the PAQ the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. In the past 12 months, the number of resident grievances alleging sexual abuse resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith: 0.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Clients/residents who allege sexual abuse and sexual harassment by staff or other clients/residents, and whose allegations are proven by investigators to be false will be held accountable through all means available to the agency” (p. 15).

· The DYS policy further confirms that facilities may discipline a youth for filling a grievance related to sexual abuse/assault/harassment only where the facility

	demonstrates that the youth field the grievance in bad faith” (p. 9). Corrective Actions: · N/A. There are no corrective actions for this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. PREA Flyer d. Resident Handbook e. Email Correspondence (Victim Advocacy Center) 2. Interviews: a. Random sample of residents - 10 b. Director c. PREA Compliance Manager 3. Corrective Action: a. Posting on Victim Advocacy and Emotional Support b. Grievance Box Pictures (2)

c. Group Session (Victim and Advocacy and Emotional Support Services)

Findings (By Provision):

115.353 (a). The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

Compliance Determination:

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

· As reported in the PAQ, the facility provides residents with access to an outside victim advocate for emotional supportive services related to sexual abuse. It further reports that the facility provides residents with access to such services by giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, State, or national victim advocacy or rape crisis organizations. The resident handbook has specific information for the residents to contact an outside advocate. The facility provides residents with access to such services by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. The facility does not provide residents with access to such services by giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for immigrant services agencies for persons detained solely for civil immigration purposes; as they do not detain for civil immigration.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that:

Victim advocates from the Baldwin County Child Advocacy Center can be available at the forensic medical examination. This service is available to all Pathway of Baldwin County clients. A Memorandum of Understanding (MOU) has been signed between Pathway and the Baldwin County Child Advocacy Center. If requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member can accompany and support the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals (p. 9).

Resident Handbook states:

If you need to report sexual harassment, sexual abuse, staff sexual misconduct, retaliation by other clients or staff members for reporting sexual abuse/harassment/

misconduct, or staff neglect that may have contributed to any of the above incidents, you can use the following reporting methods:

· Make a written report by completing a Grievance Form, which can be turned into to the PREA Compliance Manager/Program Director

· Make a verbal report by asking to speak with your therapist, the shift leader on duty, or the PREA Compliance Manager/Program Director

· Make a written or verbal report to any staff member that you trust (Group leader, Teacher, Nurse, Food Service Staff, etc.)

· Ask to call the Rape Crisis Hotline

· Report anonymously to Pathway by completing a Grievance Form without signing the form and placing the form in the locked Grievance Box

· Report anonymously to a third party by writing a letter/filling out an unsigned grievance form and placing it in a pre-addressed/stamped envelope that will be provided to you at intake. You can place this envelop in the locked Grievance Box.

If you have experienced sexual abuse or sexual harassment at Pathway, we will provide you with access to a victim advocate from the Child Advocacy Center upon request who will provide emotional support services throughout the investigative process. To request access to a victim advocate, speak with your therapist or make a written request to your therapist, or the PREA Compliance Manager.

PREA Flyer: The PREA flyer states that “you can contact the National Rape Crisis Center by Requesting to speak with a supervisor or therapist. They will assist you by calling 1800-656-Hope. The flyer further indicates that there is a limitation to confidentiality.

Email correspondence with the victim advocacy center, confirmed that the victim advocacy center identified by the agency contract can provide victim advocacy and emotional supportive services for residents at the program.

Site Review:

During the site review, the auditor noted the following:

Signage Clarity and Accessibility:
Initially, the signage was too complex for the average resident. However, it has been updated to a middle school reading level for better understanding.
Signage about emotional and victim advocacy support services was not available at first. During the review, the site added new signage detailing these services and how to access them by phone or mail.
Signage is available in both English and Spanish.
The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is

	also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report. Residents with the need to access civil immigration services would not be screened for placement at the program, therefore the facility does not provide information relate to civil immigration services. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. The agency site contact information needed to be updated. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. There are no separate programming or work areas. Visitation occurs on the housing unit. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand various methods to report incidents. Various methods identified included reporting to trusted staff member, writing a letter to staff, write a DYS grievance, tell family, or anyone on the outside that you trust. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. TESTING ACCESS TO OUTSIDE EMOTIONAL SUPPORT SERVICES Outside Emotional Support via Phone · Current Status: o During the site review, it was noted that there was insufficient information readily available on emotional support and victim advocacy services. · Findings: o Informal conversations with staff and residents revealed a lack of direct knowledge or information regarding victim advocacy and emotional support services. · Corrective Action: o In response to this finding, the facility has since created and posted detailed information about victim advocacy and emotional support services, including relevant phone numbers and mailing addresses. Outside Emotional Support via Mail

Processes for Sending and Receiving Mail

· Outgoing Mail:

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

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

§ Mental health staff deliver these envelopes to administrative staff.

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

§ The mail clerk confirmed that resident mail is not read before being sent; they only stamp the envelope and ensure it is dispatched.

· Incoming Mail:

o The process for handling incoming mail is similar:

§ The mail clerk verifies that incoming mail is from an approved sender.

§ Residents open their mail in front of staff and shake the envelope to ensure nothing is concealed.

§ Although the facility lacks a locked or secured mail drop box, all incoming and outgoing mail is logged, as observed by the auditor. Mail access is managed by the mental health staff and the mail clerk.

· Informal Conversations:

o Informal discussions with the mail clerk confirmed that while residents are given envelopes and the mail clerk applies stamps, no resident mail is read. Mailings to outside victim advocacy and emotional support services are logged only in the mail logbook.

Interviews

Resident in Custody Interview Questionnaire – Four of the ten interviewed residents reported that they are aware of services that deal with sexual abuse outside of the facility. When asked about the services, their responses varied from a local counseling organization, a hotline number, and information provided at the detention center. The residents were asked whether or not the facility provided them with mailing addresses and telephone numbers, the residents reported seeing posted and/or in the handbook. When asked if the telephone numbers were tool free all of the residents reported “yes.” The residents further reported that if they needed to contact the services, however they would have asked staff for to call the line. The residents reported that they have not tried to talk to anyone from the services assistance, so they are not sure how that process would work. Three of the residents reported that they if they contacted the services the conversation would

remain private.

Corrective Actions:

· During the site review, the auditor found that residents were not adequately informed about victim advocacy and emotional support services. Although there were postings on the walls, residents were unaware of the services available and how to access them. The facility will develop a plan to incorporate information about advocacy and emotional support services into the intake process and conduct a group session with current residents to educate them on these services. Additionally, the facility must provide documentation confirming that the group session occurred and that these services were integrated into the intake process.

Corrective Action Implemented: It should be noted that during the site review, the facility added additional postings in the housing areas with information on victim advocacy and emotional support services. The site provided two recent intake forms, commenting how the intake staff educated new intakes on victim advocacy and emotional support, in addition to showing the residents where the information was located on the posters. The facility provided documentation that twelve residents received a group session discussing emotional support and advocacy support services.

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

15.353 (b). The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Compliance Determination:

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

· As reported in the PAQ the facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. It was also reported that the facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law.

· The PREA Flyer provides general information on the zero tolerance for sexual abuse and sexual harassment. Along with the numbers for the rape crisis center, and limitations to confidentiality.

· PREA Flyer: The PREA flyer states that “you can contact the National Rape Crisis Center by Requesting to speak with a supervisor or therapist. They will assist you by calling 1800-656-Hope. The flyer further indicates that there is a limitation to

confidentiality along with the mandated reporting requirements.

· It should also be noted that the MOU with the Southeast Alabama Child Advocacy Center Dothan, states that the facility shall provide clients with confidential access to the Center via phone or mail.

Interviews

Residents(s) in custody Interview Questionnaire: Out of the ten residents in custody that were interviewed, four stated that they were aware of counseling services outside the facility that specifically address issues related to sexual abuse. However, these residents indicated that if they required access to such services, they would approach the staff for assistance. When questioned about whether the conversations with people from these services would be told to or listened to by someone else, the residents felt that they would have to ask staff for assistance and one resident reported that staff would have to report abuse to law enforcement.

Child Advocacy Center- The auditor spoke to leadership at the advocacy center in reference to the relationship with the juvenile detention center. It was reported they would first check on the status of the youth, and they would be able to provide counseling for the juvenile and the family; along with goods assistance services if needed. Additionally, it was stated that emotional support and advocacy services would be available to assist the juvenile and family through the process and they have contracted services for the counseling services. They have not received any request for services from the facility in the last 12 months.

Corrective Actions:

· During the site review, the auditor found that residents were not adequately informed about victim advocacy and emotional support services. Although there were posters on the walls, residents were unaware of the services available and how to access them. The signage informs residents that there are limitations to confidentiality based on mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to the outside victim advocates.

The facility will develop a plan to incorporate information about advocacy and emotional support services into the intake process and conduct a group session with current residents to educate them on these services. Additionally, the facility must provide documentation confirming that the group session occurred and that these services were integrated into the intake process.

Corrective Action Implemented: It should be noted that during the site review, the facility added additional postings in the housing areas with information on victim advocacy and emotional support services. The facility provided documentation that twelve residents received a group session discussing emotional support and advocacy support services.

Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility is fully compliant with this provision. 115.353 (c). The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility does not maintain memoranda of understandings or other agency agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. · MOU Southeast Alabama Child Advocacy Center (CAC) provides guidance on access to outside emotional support services that are provided through the CAC. More specifically the agreement states that the advocacy center will provide follow up services and crisis intervention contacts to victims of sexual assault at Pathway, as necessary as resources allow. · Email correspondence with the victim advocacy center, confirmed that the victim advocacy center identified by the agency contract can provide victim advocacy and emotional supportive services for residents at the program. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.353 (d). The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides residents with reasonable and confidential access to their attorneys or other legal representation, and parents or legal guardians. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Clients/Residents are provided reasonable and confidential access to their attorneys, other legal representation, and their parents/

	legal guardians” (p. 16). Interviews Director: The residents are provided meaningful and confidential access to their attorneys and other legal representation/parents/guardians. The therapist would coordinate meetings as requested. Clients are allowed to contact their families via phone with the therapist. Parents are allowed to attend visitation once monthly. Home passes are allowed once the client earns the opportunity to attend. Family counseling can be scheduled by appointment with the therapist, lastly clients are allowed to write their families. PREA Compliance Manager: The interviewed staff reported that the residents can have access to a phone. It’s typically through pone calls where they would talk to their attorney or leagal representation. The therapist will coordinate usually the attorney’s will initiate the call. If needed or requiested we will create a confidential space. The residents have weekly phone calls and access to parents and legal guardians. Resident in Custody Interview Questionnaire – Half of the interview residents reported that they could talk with the lawyer in private. The other residents interviewed reported being unsure or did not think they could. It should also be noted that most of the residents did not have an attorney so they were not aware of the process. All of the residents reported that they could talk to the family members that were on an approved list. The residents stated that they could have visitation and phone calls. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility is in corrective action to address educating existing residents on victim advocacy and emotional support. The corrective actions were completed and follow-up reviewed confirmed that the handbook was updated and victim advocacy and emotional support education was provided to residents. With these measures in place, the initial audit findings are resolved and the facility is compliant with the provisions of the standard.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual · Pathway website: https://www.pathway-inc.com/_files/ugd/139228_ea9b8d3d1c9744cfafad05632b8786e6.pdf 2. Corrective Actions: · Fixed Grievance Boxes · Updated Handbook Findings (By Provision): 115.354 (a). The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment, and the agency/facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: Pathway permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist clients/residents in filing requests for administrative remedies relating to allegations of sexual abuse, and file such requests on behalf of clients/residents. Clients are encouraged to report any act of sexual abuse or sexual harassment that they have witnessed or suspect. Third Party Reports from staff are required if they witness or suspect potential sexual abuse or sexual harassment in congruence with Pathway’s no tolerance policy.

	If a client declines to have third-party assistance in filing a grievance alleging sexual abuse, Pathway documents the client's/resident's decision to decline. Pathway allows parents or legal guardians of clients/residents to file a grievance alleging sexual abuse, including appeals, on behalf of such client/resident, regardless of whether or not the client/resident agrees to having the grievance filed on their behalf. Clients/Residents are provided reasonable and confidential access to their attorneys, other legal representation, and their parents/legal guardians (p.16). · The website link contains the third party reporting form: : https://www.pathway-inc.com/_files/ugd/139228_ea9b8d3d1c9744cfafad05632b8786e6.pdf Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: Initially, the signage was too complex for the average resident. However, it has been updated to a middle school reading level for better understanding. Signage about emotional and victim advocacy support services was not available at first. During the review, the site added new signage detailing these services and how to access them by phone or mail. Signage is available in both English and Spanish. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. The agency site contact information needed to be updated. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented

corrective actions to improve awareness and access to these services.
TESTING THIRD-PARTY REPORTING
Testing the Third-Party Reporting Method:

The auditor evaluated the third-party reporting process using the method publicly available, such as through the agency or facility website.
The method for third-party reporting posted on the website was confirmed to be easily accessible and understandable, and it is prominently featured on the agency's PREA site.
A test report was submitted by the auditor, and an immediate response was received from the facility indicating that follow-up contact would be made regarding the report.
The auditor received follow-up correspondence from the PREA coordinator confirming that the report had been acknowledged.
Evidence was provided via email showing that the report was received by the facility.

Corrective Actions:

· Grievance Box: The auditor observed that the grievance box in one unit was on a table, having come off the wall, while in another unit, the grievance box was hanging by just one screw. Although the boxes are locked, the facility should ensure that they are securely attached to the wall in both units.

Corrective Action Implemented: Two pictures of the grievance boxes were provided showing that the boxes were fixed and appropriately secured on the walls.

· Handbook: The facility provides information at intake through the PREA brochure, handbook and PREA video. The Manual is not up to date and has contact information for staff that do not work at the facility. The facility shall update the manual with the correct information.

The corrective actions were completed and follow-up reviewed confirmed that the handbook was updated. With these measures in place, the initial audit findings are resolved and the facility is compliant with the provisions of the standard.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility is in corrective action to update the resident handbook.

The corrective actions were completed and follow up reviewed confirmed that the handbook was updated. With these measures in place, the initial audit findings are resolved and the facility is compliant with the provisions of the standard.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Code of Alabama 26-14-3 d. Investigations (3) 2. Interviews: a. Random sample of staff - 8 b. Medical and mental health staff (1) c. Director d. PREA Compliance Manager Findings (By Provision): 115.361 (a). The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. The agency requires all staff to report immediately and according to agency policy any retaliation against residents or staff who reported such an incident. The agency requires all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

	· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "All staff are required to report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment occurring at Pathway; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation" (p. 15). · Code of Alabama 26-14-3 provides the state mandatory reporting laws. Interviews: Random Sample of Staff - The interviewed staff report that the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that have contributed to an incident or retaliation. It was further reported that such information would be reported to the Director, Supervisor, or PREA Coordinator. Reports are made immediately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.361 (b). The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws. Compliance Determination: The facility has demonstrated compliance with provision of the standard because: · As reported in the PAQ, the facility requires that all staff comply with any applicable mandatory child abuse reporting laws. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Staff are required to comply with all applicable mandatory child abuse reporting laws" (p. 15). · Code of Alabama 26-14-3 provides the state mandatory reporting laws. Interviews Random Sample of Staff: Eight random staff interviews; indicated a clear understanding of the duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents(s) in custody or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation immediately. The various ways staff indicated that they could make a report included, but was not limited to:

	· Report to supervisor /PREA Coordinator · Call the PREA Hotline · Complete an incident or grievance report Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.361 (c). Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, apart from reporting to the designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Apart from reporting to designated supervisors or officials and designated State or local service agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than the extent necessary, to make treatment, investigation, and other security and management decisions” (p. 15). Interviews Random Sample of Staff: As previously stated, the interviewed random sample of staff indicated a clear understanding of the duty to report the above-mentioned immediately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.361 (d). Medical and mental health practitioners shall be required to report

	sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws. (2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Incidents that were reported: there was one reported allegation that appears to have been reported to the mental health staff. The staff immediately reported the incident. Interviews Medical and Mental Health Staff: The interviewed staff reported that they are required to disclose limitation of confidentiality and they have a duty to report upon initiation of services. They are also required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official immediately upon learning of it. The residents come into the facility; we go over that information with them. We also verify there understanding of what was discussed. I have become aware of a sexual harassment allegation. It was reported by me and I reported to the immediate supervisor. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.361 (e). Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Incidents that were reported. There were no reported allegations of sexual abuse.

	Interviews PREA Compliance Manager – The interviewed staff reported that if the facility receives an allegation of sexual abuse, staff report to leadership, we will notify law enforcement or the PREA Coordinator; and we notify DHR for sexual abuse allegations. Additionally, we will notify parents and legal guardians. Director – When the facility receives an allegation of sexual abuse the response would be to report to DYS, local Law Enforcement, and the Department of Human Resources. From there the alleged victims and perpetrators parent/guardian and probation officer will be notified. If the victim is in child welfare system, the caseworker would be notified. Notifications are made at the time of the report. Procedures are in place to handle instances where reports occurring after business hours occur to ensure a timely response. The Juvenile Probation Officer would be notified, and if they ask to speak to their attorney, we will allow them to. The Probation Officer are notified the same business day or the next business day if after hours. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.361 (f). The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigation Report: The three reported allegations were immediately investigated. Interviews Director: All allegations of sexual abuse and sexual harassment are reported to the facility PREA compliance manager and PREA Coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility

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

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Investigations (3) 2. Interviews: a. Agency head b. Director c. Random sample of staff - 8 Findings (By Provision): 115.362 (a). When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. In the past 12 months, the number of times the agency or facility has determined that a resident was subject to a substantial risk of imminent sexual abuse: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual provides the following guidance:

	An emergency grievance can be filed alleging substantial risk of imminent sexual abuse. Emergency grievances require an initial response within 48 hours and must be immediately reported to the PREA Compliance Manager for review. With the guidance of the PREA Compliance Manager, staff will take immediate action to protect the client/resident from potential imminent sexual abuse. A final decision regarding an emergency grievance shall be made and issued within 5 days (pp. 16-17). · The facility documents on the investigation report any actions taken. For example after the sexual harassment allegations, the facility documented that involved parties were immediately separated. Interviews Agency Head: The interviewed agency head reported that when they learn that resident is subject to a substantial risk of imminent sexual abuse, immediate protective actions are taken by the facility. The client is moved to a safe location and the alleged abuser is removed or placed under increased supervision by staff. This would occur immediately. Director: If there is an instance where a resident is subject to a substantial risk of imminent sexual abuse immediate protective measures would take place. There have been no instances of such risk; however, in such a circumstance, the client would be immediately moved to a safe area and placed on a 1:1 ratio. Actions would be taken against the potential abuser to prevent abuse to others, up to and including discharge from the facility or immediate termination if this is a staff member. Staff are expected to respond the moment they are aware of the risk. Random Sample of Staff - The interviewed staff reported that if they learn that a resident is at risk of imminent sexual abuse, the actions taken to protect the residents include separate if roommates, keep them apart, make sure they are safe, and immediately make a report and notify the director. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual 2. Interviews: a. Agency head b. Director 115.363 (a). Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. In the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: 0. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.363 (b). Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Upon receiving an allegation that a client was sexually abused while confined at another facility, the Director shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. This notification will be done as soon as possible but no later than 72 hours" (p. 16). A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.363 (c). The agency shall document that it has provided such notification. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "This notification shall be documented in the client's chart" (p. 16). Corrective Actions: N/A. There are no corrective actions for this provision. 115.363 (d). The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ, the agency or facility requires that all allegations received from other agencies or facilities are investigated in accordance with the PREA standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that ““Reports made from other agencies or facilities will be investigated in accordance with the PREA standards” (p. 16). Interviews Agency Head: The interviewed staff reported that if another agency or facility within your agency refers allegations of sexual abuse or sexual harassment that occurred within one of the facilities the head of the agency where the alleged abuse occurred will be notified asap AND appropriate investigative agency will be notified. This is documented as well. There are no none examples. Director: If there is an allegation from another facility or agency the allegation should be referred to be investigated. It would be investigated by our Policy standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Investigations (3) 2. Interviews: a. Random sample of staff/Security Staff First Responders- 8

	115.364. (a). Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to: (1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a first responder policy for allegations of sexual abuse. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report separate the alleged victim and abuser. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. policy requires that, if the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The policy requires that, if the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. In the past 12 months, the number of allegations that a resident was sexually abused: 0. Of these allegations, the number of times the first security staff member responded to the report separated the alleged victim and abuser: 0.In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: 0.Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report preserved and protected any crime scene until appropriate steps could be taken to collect any evidence: 0.Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report requested that the alleged victim not take any actions that

	could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating: 0.Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report ensured that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: OFFICIAL RESPONSE FOLLOWING A CLIENT/RESIDENT REPORT/COORDINATED RESPONSE-Should a client/resident report a sexual abuse/assault by another client/ resident or staff, the following protocol should be followed: Staff shall immediately separate the alleged victim and abuser. The alleged victim may be placed in isolation to keep them safe from the alleged abuser only as a last resort if less restrictive measures are inadequate to keep them and other clients/residents safe and only until an alternative means of keeping all clients/residents safe can be arranged. Pathway will follow all requirements related to isolation (see Section IV, number 13). Staff shall preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. If the report is made immediately following the abuse/assault and the victim has not showered, the victim shall remain in the accompaniment of staff and be instructed not to shower or change clothes, brush their teeth, etc. Ensure the alleged abuser does not take any actions that could destroy physical evidence as appropriate (washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, and eating). The staff shall immediately contact 911 for police and ambulance to respond if the victim needs medical attention. Staff is to request a police officer from the sexual abuse/assault unit. PREA Compliance Manager shall promptly report the allegation to the Department of Human Resources as well as the client’s legal guardian, unless Pathway has official documentation showing the legal guardian should not be notified. After hours, the staff on duty shall contact the PREA Compliance Manager and PREA Coordinator for additional instructions and support (may need additional staff to report to facility). During business hours, the PREA Compliance Manager or designee shall be contacted as soon as possible. The PREA Compliance Manager will be responsible for notifying the PREA Coordinator, who will notify the Chief Executive Officer as appropriate.

	The PREA Compliance Manager or designee will contact the referring agency and inform them of the situation. In cooperation with the local authorities, Pathway will determine the status of the accused. If the accused is not immediately taken into custody, Pathway management will evaluate and determine if the accused will be removed/terminated from the treatment program. Staff are to secure the area where the abuse took place, restricting it from client and staff access until the area is released by the police responding to the incident. Staff should attempt to obtain a written statement from the victim. Staff will also prepare a written report detailing what the client/resident reported to the staff member, additional information regarding observed evidence, actions taken, etc. At any time, the client/resident victim may refuse to participate in the process and not proceed with the investigation/reporting. The client/resident shall not be punished for refusing to cooperate with the investigation. Pathway will work with community resources and the client/resident to ensure that communications with community resources/advocates are confidential to the extent allowable by law. Prior to referral to a community resource, Pathway will inform client/resident of the extent to which client/resident may expect such communications to remain confidential. The client/resident may also report a sexual abuse/assault through a grievance form at any time, regardless of the time frame in which the alleged incident occurred. The client/resident shall be separated from the accused and the victim shall be encouraged to report the incident to the police and receive medical attention/ evaluation. The same attention and services will be offered to a client/resident who reports sexual abuse days or weeks after the alleged abuse. All allegations of sexual abuse/assault shall be taken seriously by staff, recognized as traumatic to the client/resident victim and staff shall be sensitive at all times to the needs and emotions of the victim. Confidentiality and client/resident privacy shall be maintained at all times, with only those who have a direct "need to know" having access to the personal information and details of the victim and alleged perpetrator. If a client/resident does not believe their accusations of sexual abuse/assault were responded to appropriately, they do not feel safe as a result of the abuse, or any other concerns regarding the alleged abuse, they may submit a written grievance following the grievance chain of command up to the agency Chief Executive Officer. The decision and response of the agency Chief Executive Officer is final. As the needs of the client/resident victim are being met, the agency shall assemble the Sexual Abuse Response Team (SART), which may include: the client/resident's Therapist, Senior Shift Leader Supervisor, PREA Compliance Manager, PREA Coordinator, Director, and Chief Executive Officer. · The SART will ensure that the clients are safe, and the victim is being cared

	for physically and emotionally. · The SART will ensure that policies and procedures are being followed. · The SART will review the incident and evaluate what possible warning signs were missed. If anything could have been done to prevent the abuse, a corrective action plan will be implemented to prevent an abuse from happening again in the same manner/location, etc. · SART will ensure that the referring agencies are kept informed, and information is relayed between appropriate parties. · The SART will assist in monitoring for potential retaliation. · The SART will maintain investigative records of alleged sexual abuse or harassment as long as the alleged abuser is incarcerated or employed by Pathway plus five years. If an allegation that is reported to and investigated by the appropriate legal authority does not result in criminal charges or disciplinary actions from that body, Pathway reserves the right to conduct an internal investigation. This investigation seeks to determine risk that the abuse/misconduct occurred and will provide Pathway with the opportunity to take the appropriate actions according to agency policy. Incident reports, investigations and results on client/resident sexual abuse/ misconduct will be retained for seven years; statistical data on sexual abuse/assault will be retained for ten years (pp.17-19). · Investigations: Upon review, there were no reported allegations of sexual abuse. Interviews Random Sample of Staff/ Security Staff and Non-Security Staff First Responders – The interviewed random staff reported that if they are first person to be alerted that a resident has allegedly been the victim of sexual abuse, their responsibilities include: secure area, separate involved parties, not allow them to shower or use the bathrooms, notify police and the supervisor. When probed most staff reported that they would not share with the other residents. It should also be noted that all staff are considered first responders. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.364 (b). If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could

	destroy physical evidence, and then notify security staff. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ all staff members are considered first responders. Of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: 0. It further states that all employees are considered security staff and first responders. · Investigations: Upon review, there were no reported allegations of sexual abuse. Interviews Random Sample of Staff/ Security Staff and Non-Security Staff First Responders – The interviewed random staff reported that if they are first person to be alerted that a resident has allegedly been the victim of sexual abuse, their responsibilities include: secure area, separate involved parties, not allow them to shower or use the bathrooms, notify police and the supervisor. When probed most staff reported that they would not share with the other residents. It should also be noted that all staff are considered first responders. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.365	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents:

	a. Pre-Audit Questionnaire (PAQ) b. Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual 2. Interviews: a. Director Findings (By Provision): 115.365 (a). The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. · The facility does not have a separate written institutional plan. The written institutional plan is incorporated in the below policy. · OFFICIAL RESPONSE FOLLOWING A CLIENT/RESIDENT REPORT/COORDINATED RESPONSE-Should a client/resident report a sexual abuse/assault by another client/ resident or staff, the following protocol should be followed: Staff shall immediately separate the alleged victim and abuser. The alleged victim may be placed in isolation to keep them safe from the alleged abuser only as a last resort if less restrictive measures are inadequate to keep them and other clients/residents safe and only until an alternative means of keeping all clients/residents safe can be arranged. Pathway will follow all requirements related to isolation (see Section IV, number 13). Staff shall preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. If the report is made immediately following the abuse/assault and the victim has not showered, the victim shall remain in the accompaniment of staff and be instructed not to shower or change clothes, brush their teeth, etc. Ensure the alleged abuser does not take any actions that could destroy physical evidence as appropriate (washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, and eating). The staff shall immediately contact 911 for police and ambulance to respond if the victim needs medical attention. Staff is to request a police officer from the sexual

	abuse/assault unit. PREA Compliance Manager shall promptly report the allegation to the Department of Human Resources as well as the client's legal guardian, unless Pathway has official documentation showing the legal guardian should not be notified. After hours, the staff on duty shall contact the PREA Compliance Manager and PREA Coordinator for additional instructions and support (may need additional staff to report to facility). During business hours, the PREA Compliance Manager or designee shall be contacted as soon as possible. The PREA Compliance Manager will be responsible for notifying the PREA Coordinator, who will notify the Chief Executive Officer as appropriate. The PREA Compliance Manager or designee will contact the referring agency and inform them of the situation. In cooperation with the local authorities, Pathway will determine the status of the accused. If the accused is not immediately taken into custody, Pathway management will evaluate and determine if the accused will be removed/terminated from the treatment program. Staff are to secure the area where the abuse took place, restricting it from client and staff access until the area is released by the police responding to the incident. Staff should attempt to obtain a written statement from the victim. Staff will also prepare a written report detailing what the client/resident reported to the staff member, additional information regarding observed evidence, actions taken, etc. At any time, the client/resident victim may refuse to participate in the process and not proceed with the investigation/reporting. The client/resident shall not be punished for refusing to cooperate with the investigation. Pathway will work with community resources and the client/resident to ensure that communications with community resources/advocates are confidential to the extent allowable by law. Prior to referral to a community resource, Pathway will inform client/resident of the extent to which client/resident may expect such communications to remain confidential. The client/resident may also report a sexual abuse/assault through a grievance form at any time, regardless of the time frame in which the alleged incident occurred. The client/resident shall be separated from the accused and the victim shall be encouraged to report the incident to the police and receive medical attention/ evaluation. The same attention and services will be offered to a client/resident who reports sexual abuse days or weeks after the alleged abuse. All allegations of sexual abuse/assault shall be taken seriously by staff, recognized as traumatic to the client/resident victim and staff shall be sensitive at all times to the needs and emotions of the victim. Confidentiality and client/resident privacy shall be maintained at all times, with only those who have a direct "need to know" having access to the personal information

	and details of the victim and alleged perpetrator. If a client/resident does not believe their accusations of sexual abuse/assault were responded to appropriately, they do not feel safe as a result of the abuse, or any other concerns regarding the alleged abuse, they may submit a written grievance following the grievance chain of command up to the agency Chief Executive Officer. The decision and response of the agency Chief Executive Officer is final. As the needs of the client/resident victim are being met, the agency shall assemble the Sexual Abuse Response Team (SART), which may include: the client/resident's Therapist, Senior Shift Leader Supervisor, PREA Compliance Manager, PREA Coordinator, Director, and Chief Executive Officer. · The SART will ensure that the clients are safe, and the victim is being cared for physically and emotionally. · The SART will ensure that policies and procedures are being followed. · The SART will review the incident and evaluate what possible warning signs were missed. If anything could have been done to prevent the abuse, a corrective action plan will be implemented to prevent an abuse from happening again in the same manner/location, etc. · SART will ensure that the referring agencies are kept informed, and information is relayed between appropriate parties. · The SART will assist in monitoring for potential retaliation. · The SART will maintain investigative records of alleged sexual abuse or harassment as long as the alleged abuser is incarcerated or employed by Pathway plus five years. · If an allegation that is reported to and investigated by the appropriate legal authority does not result in criminal charges or disciplinary actions from that body, Pathway reserves the right to conduct an internal investigation. This investigation seeks to determine risk that the abuse/misconduct occurred and will provide Pathway with the opportunity to take the appropriate actions according to agency policy. · Incident reports, investigations and results on client/resident sexual abuse/ misconduct will be retained for seven years; statistical data on sexual abuse/assault will be retained for ten years (pp.17-19). Interviews Director: All levels of staffing are provided training on how to respond to incidents of sexual abuse or sexual harassment. Pathway has a Sexual Abuse Response Team who would respond in the event of an allegation of sexual abuse. Members of the SART would ensure proper communication and documentation occurs. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.366	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) 2. Interviews: a. Agency head Findings (By Provision): 115.366 (a). Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A-As reported in the PAQ, the agency, facility, or any other government entity responsible for collective bargaining on the agency’s behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later.

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

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual 2. Interviews: a. Agency head b. Director c. Designated staff member charged with monitoring retaliation

3. Corrective Action:

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

Findings (By Provision):

115.367 (a). The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.

Compliance Determination:

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

· As reported in the PAQ, the facility has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency has a designated staff charged with monitoring for retaliation.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway shall protect all clients and staff who report sexual abuse or sexual harassment and cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.

Pathway shall employ multiple protection measures, including housing changes or transfers for client victims or abusers, removal of alleged staff or client abusers from contact with victims, and emotional support services for clients or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of clients or staff who reported the sexual abuse and of clients who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by clients or staff and shall act promptly to remedy any such retaliation. Items Pathway shall monitor include any client disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. Pathway shall continue such monitoring beyond 90 days if the initial monitoring indicates a continued need.

In regard to clients, this monitoring shall also include periodic status checks.

If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.

Pathway’s obligation to monitor shall terminate if Pathway determines that the allegation is unfounded (p. 17).

Corrective Actions:

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

115.367 (b). The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

Compliance Determination:

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

· The facility reported in the PAQ, that zero residents that were placed on segregated housing after reporting sexual abuse or sexual harassment.

· There was one allegation of sexual abuse against a staff member reviewed. Based on the documentation provided the auditor could not determine whether monitoring for retaliation occurred.

Interviews

Agency Head: The interviewed agency head reported that there is a designated staff member (SSLS) who monitor for such retaliation. We will ensure the staff member and client in question have minimal interaction by not assigning the staff member to the client's team if necessary or move the client to another team/caseload (if staff in question is client's therapist). Clients will also receive counseling in an effort to process the feelings and help monitor for retaliation.

Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The interviewed staff reported that as the Manager, part of my responsibility is to ensure that clients and staff do not retaliate against reporters of sexual abuse and sexual harassment. Monitoring would occur by ensuring clients nor staff retaliate against reports of sexual abuse and sexual harassment. This is done by monitoring the day-to-day interactions with staff and clients, review of consequences given to clients or disciplinary actions by supervisor to staff, and regular interactions with clients/staff. If retaliation is suspected, clients can be moved to another housing unit, and staff would be placed on leave pending the investigation. Contact would be initiated with the clients. There would be close monitoring as well as therapeutic support.

Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – During the site review there were no residents identified that were placed in isolation.

Residents who Reported a Sexual Abuse – During the site review, there were no residents identified that had reported sexual abuse.

	Corrective Actions: · The auditor could not determine whether monitoring for retaliation occurred regarding residents and staff. The facility shall conduct additional training to staff responsible or monitoring for retaliation and conduct a table top exercise showing how the retaliation would be monitored. Additionally, the facility shall provide documentation of any allegations of sexual abuse that were reported since the onsite visit. Due Date: November 30, 2024. Corrective Action Implemented: The facility provided documentation on the investigation process along with monitoring for retaliation. The training met the requirements of the provision. No further action is required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.367 (c). For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency/facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. It was further reported that the agency/ facility acts promptly to remedy any such retaliation; and the agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The number of times an incident of retaliation occurred in the past 12 months: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of clients or staff who reported the sexual abuse and of clients who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by clients or staff, and shall act promptly to remedy any such retaliation. Items Pathway shall monitor include any client disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. Pathway shall continue

such monitoring beyond 90 days if the initial monitoring indicates a continued need" (p. 17).

· There was one allegation of sexual abuse against a staff member reviewed. Based on the documentation provided the auditor could not determine whether monitoring for retaliation occurred.

Interviews

Director: The interviewed staff reported that when a client alleges sexual abuse or sexual harassment by a staff member, the staff member is not permitted to return to work until the investigation has cleared them of wrongdoing or they are terminated due to the findings of the investigation. If the allegation involves another client, the clients are immediately separated due to the findings of the investigation. If the allegation involves another client, the clients are immediately separated and the alleged abuser is monitored closely for continued abuse of others. They could also be removed from the program if warranted. Therapist continue to meet with clients weekly to ensure the clients are receiving paper counseling as well as to allow opportunities to report retaliation. Additionally, the program director is tasked with monitoring for retaliation, which includes random checks and regular meetings with the alleged victim to ensure the needs are met.

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

Corrective Actions:

· The auditor could not determine whether monitoring for retaliation occurred regarding residents and staff. The facility shall conduct additional training for staff responsible for monitoring for retaliation and conduct a tabletop exercise showing how the retaliation would be monitored. Additionally, the facility shall provide documentation of any allegations of sexual abuse that were reported since the onsite visit.

Due Date: November 30, 2024.

Corrective Action Implemented: The facility provided documentation on the investigation process along with monitoring for retaliation. The training met the requirements of the provision. No further action is required.

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

115.367 (d). In the case of residents, such monitoring shall also include periodic

	status checks. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · There were zero reported allegations of sexual abuse that occurred in the last 12 months. Hello upon further review the auditor determined that there was one allegation that was reported to be sexual abuse. · There was one allegation of sexual abuse against a staff member reviewed. Based on the documentation provided the auditor could not determine whether monitoring for retaliation occurred. Interviews Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The interviewed staff reported that when monitoring some of the things that would be looked at when it comes to detecting retaliation is aggressive behaviors, threats, fights, or arguments. Monitor would also review if there were excessive write ups, room changes, improper treatment, housing changes, change of behavior and is the youth are being treated fairly. Corrective Actions: · The auditor could not determine whether monitoring for retaliation occurred regarding residents and staff. The facility shall conduct additional training for staff responsible for monitoring for retaliation and conduct a tabletop exercise showing how the retaliation would be monitored. Additionally, the facility shall provide documentation of any allegations of sexual abuse that were reported since the onsite visit. Due Date: November 30, 2024. Corrective Action Implemented: The facility provided documentation on the investigation process along with monitoring for retaliation. The training met the requirements of the provision. No further action is required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.367 (e). If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· There were zero reported allegations of sexual abuse that occurred in the last 12 months. Hello upon further review the auditor determined that there was one allegation that was reported to be sexual abuse. · There was one allegation of sexual abuse against a staff member reviewed. Based on the documentation provided the auditor could not determine whether monitoring for retaliation occurred. Interviews Agency Head: The interviewed agency head reported that there is a designated staff member (SSLS) who monitor for such retaliation. We will ensure the staff member and client in question have minimal interaction by not assigning the staff member to the client's team if necessary or moving the client to another team/caseload (if staff in question is client's therapist). Clients will also receive counseling in an effort to process the feelings and help monitor for retaliation. Director: If retaliation occurs among clients, the alleged abuser could be removed from the program or face further consequences including added time on their treatment. If retaliation occurs by a staff member, the staff member would face immediate termination. Any suspicion of retaliation would be immediately investigated, and above consequences instituted. Corrective Actions: · The auditor could not determine whether monitoring for retaliation occurred regarding residents and staff. The facility shall conduct additional training for staff responsible for monitoring for retaliation and conduct a tabletop exercise showing how the retaliation would be monitored. Additionally, the facility shall provide documentation of any allegations of sexual abuse that were reported since the onsite visit. Due Date: November 30, 2024. Corrective Action Implemented: The facility provided documentation on the investigation process along with monitoring for retaliation. The training met the requirements of the provision. No further action is required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.367 (f). The auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility has corrective action associated with monitoring for retaliation.

	The corrective actions were completed, and follow-up was reviewed. With these measures in place, the initial audit findings are resolved, and the facility is compliant with the provisions of the standard.

115.368	**Post-allegation protective custody**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual 2. Interviews: a. Director b. Staff who supervise residents in isolation c. Medical and mental health staff (1) Findings (By Provision): 115.368 (a). Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.342. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. It was further reported that the facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. If a resident who is alleged to have suffered sexual abuse is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population. · Policy The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and

	Procedures Manual “states that The alleged victim may be placed in isolation to keep them safe from the alleged abuser only as a last resort if less restrictive measures are inadequate to keep them and other clients/residents safe and only until an alternative means of keeping all clients/residents safe can be arranged. Pathway will follow all requirements related to isolation (see Section IV, number 13)” (p. 17). The policy further states that “If isolation lasts longer than 30 days, Pathway shall afford each client a review to determine whether there is a continuing need for separation from the general population” (p. 13). Interviews Director: The interviewed director reported that they have not had any instances of isolation due to sexual abuse allegation. Isolation would be used as a last resort. True isolation is not used as we do not have isolation rooms. Clients would be placed on a 1:1 ratio away from others to protect them. Medical and Mental Health Staff: The interviewed staff reported that if a resident were in isolation, they would receive visits from medical and mental health staff. It was further reported that there is no isolation but a cool off room and the residents may be in there for 15 minutes. Mental health staff office is on the unit, and we will continue meeting with them while in the cool off. Part of the process for my role is to assist with regulating them. Staff who Supervise Residents in Isolation – All direct care staff at the facility can supervise a resident in isolation. The staff reported that they have never had to use the process, but if so, it is a temporary limited time process that they would use to regain control of the resident. The interviewed staff further reported that they would have to involve the Director. The residents would not be in isolation long enough to be restricted from any service. The clinician is housed on the unit and medical staff will come to the unit as needed to render services to any resident. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – During the onsite audit and upon file review there were no residents held in isolation. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting (2) d. Investigations (2) 2. Interviews: a. Investigative staff - 1 b. Director c. PREA coordinator d. PREA Compliance Manager 3. Corrective Action Pending: a. Retrain Investigation Staff Material and Roster (5) Findings (By Provision): 115.371 (a). When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency/facility has a policy related to criminal and administrative agency investigations. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: INVESTIGATIONS POLICY: It is the general policy of Pathway that all incidents of suspected sexual harassment or sexual abuse be adequately addressed through

	inquiry or investigation. Any allegation that involves potentially criminal behavior will be immediately reported to local law enforcement and the Department of Human Resources. Sexual Harassment: When allegations of sexual harassment are made, investigations shall take place under the following guidelines: Client/Resident to Client/Resident: The PREA Compliance Manager, his/her designee or the PREA Coordinator shall investigate questioning all parties involved to determine what happened and direct action to prevent further incidents. The Department of Youth Services and Department of Human Resources and all other licensing authorities will be notified of the findings and the PREA Compliance Manager/designee or PREA Coordinator shall file appropriate reports. Staff to Client/Resident: The PREA Compliance Manager, designee and the PREA Coordinator shall investigate, questioning all relevant parties to determine what happened. The Department of Youth Services and Department of Human Resources and all other licensing authorities will be notified of the findings and consulted in determination of actions to be taken. If the PREA Compliance Manager is involved in the allegations: His/her immediate supervisor shall conduct the investigation as noted above. Sexual Abuse: When allegations of sexual abuse/assault are made, the following shall happen: Contact local authorities immediately, if a client/resident reports a sexual assault. If the PREA Compliance Manager or PREA Coordinator is available, he/she shall take responsibility for contacting authorities. If the PREA Compliance Manager is not available, staff on duty must contact authorities without delay. If the allegations or quality of evidence suggest a crime has been committed, no further interview of the victim or perpetrator will be conducted until cleared to do so by prosecuting authority. Pathway will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. If there is a possibility of new physical evidence to be used: · Secure the area where the alleged abuse took place and do not allow residents to enter the area until police personnel have cleared the area; · Do not touch anything in the area where the alleged abuse took place other than to preserve the life or safety of an individual; · Move the alleged victim to a secure area until authorities arrive; · If conditions allow, direct the alleged perpetrator to remain in an area where they can be observed until authorities arrive;

	· Pathway staff shall cooperate with all aspects of the investigation by local authorities. The PREA Compliance Manager and PREA Coordinator shall endeavor to remain informed about the progress of the investigation and notify all program licensing authorities; · Pathway's PREA Compliance Manager/designee or PREA Coordinator shall conduct administrative investigation; · Any substantiated allegations of conduct that appear criminal will be referred for prosecution. Reporting to Clients/Residents: In the event of a client/resident allegation of sexual abuse, the PREA Compliance Manager shall: Following an investigation into a client/resident's allegation that he/she suffered sexual abuse in Pathway's facility, the PREA Compliance Manager shall inform the client/resident, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. If the Pathway did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the client/resident. Following a client's/resident's allegation that he/she was sexually abused by another client/resident, Pathway will inform the alleged victim when: · Pathway learns that the alleged abuser has been indicted on a charge related to the sexual abuse; · Pathway learns that the alleged abuser has been convicted on a charge related to sexual abuse. Following a client/resident's allegation that a staff member has committed sexual abuse against the client/resident and the findings are substantiated or unsubstantiated; the PREA Compliance Manager shall inform the client/resident whenever: · The staff member is no longer employed at the facility; · The staff is no longer posted within the client’s team · The agency learns that the staff member has been indicted on a charge related to the sexual abuse within the facility; · The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. All such notifications or attempted notifications shall be documented by the PREA Compliance Manager. The PREA Compliance Manager's obligation to report shall terminate if the client/ resident is released from Pathway's program.

	The departure of the alleged victim from the program or alleged abuser from employment or control of the program or agency shall not provide basis for terminating an investigation. Criminal and administrative agency investigations Pathway shall conduct its own investigations into allegations of sexual harassment and abuse that do not involve behavior that could potentially be criminal in nature. It shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. At any point, if it is determined that the allegation could potentially involve criminal behavior, a report will be made immediately to local law enforcement agency as well as the Department of Human Resources. Pathway shall not terminate an investigation solely because the source of the allegation recants the allegation. Administrative investigations: This should include an effort to determine whether staff actions or failures to act contributed to the abuse Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Substantiated allegations of conduct that appear to be criminal shall be referred for prosecution. Pathway shall retain all written reports for as long as the alleged abuser is enrolled or employed at Pathway, plus five years, unless the abuse was committed by a juvenile client and applicable law requires a shorter period of retention. The departure of the alleged abuser or victim from Pathway shall not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, Pathway shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Pathway shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. A decision regarding the merits of any grievance or portion of a grievance alleging sexual harassment must be made within 90 days of the filling of the grievance. Regarding allegations of sexual abuse, Pathway will make an effort to encourage the investigation agency to ensure a decision is made regarding the merits of the grievance or portion of the grievance within 90 days (19-22). · Investigation Reports: Two allegations reported were reviewed. The auditor

	could determine where an internal and external agency conducted an investigation. Interviews Investigative Staff: The interviewed staff reported that when an allegation of sexual abuse or sexual harassment is received the investigation are conducted immediately. Anonymous and third-party reports of sexual abuse are handled the same. Clients would be separated immediately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (b). Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334. Compliance Determination: Interviews Investigative Staff: The interviewed staff reported that they received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings. The training was completed online; the PREA Resource Investigative training. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (c). Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigation Reports: Two allegations reported were reviewed. The auditor could determine where an internal and external agency conducted an investigation. The allegations did not involve direct or circumstantial evidence. Interviews

	Investigative Staff: The interviewed staff reported that first steps in initiating an investigation include immediately ensuring that 1st responders do what they are supposed to do; get with the victim and perpetrator and gather statements, gather staff statements, and review video footage. If medical or mental health services are needed, it would immediately be addressed. Criminal investigations are reported immediately to the local authorities, Department of Human Resources, and the Department of Youth Services. Administrative Investigations involve gathering statements form all involved parties and collecting any other pertinent information. Direct or circumstantial evidence is handled in the following manner: statements from staff/clients and video monitoring footage would be collected. Any physical/ DNA evidence would be collected by the Local Law Enforcement Agency. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (d). The agency shall not terminate an investigation solely because the source of the allegation recants the allegation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ the facility does not terminate an investigation solely because the source of the allegation recants the allegation. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway shall not terminate an investigation solely because the source of the allegation recants the allegation” (p. 21). Interviews Investigative Staff: The staff interviewed reported that an investigation would not terminate if the source of the allegation recants their allegation. An investigation would follow, and evidence and statements will be gathered to determine if the original allegations are true. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (e). When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with

	prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigation Report: There were no allegations that were reported for criminal prosecution. Interviews: Investigative Staff: The staff interviewed reported that any incident that is potentially criminal in nature would not be investigated administratively. NO interviews would be done by Administrative Staff, this would be left to local law enforcement. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (f). The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Investigative Staff: The interviewed investigator reported the credibility is based on history of honesty/dishonesty and motivation for the involvement in the incident. Residents are not subject to a polygraph test. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (g). Administrative investigations: (1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) Shall be documented in written reports that include a description of the physical and

testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

Compliance Determination:

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

· Investigation Reports: Two allegations reported were reviewed. The auditor could determine where an internal and external agency conducted an investigation. The investigations provided documentation of the written report.

Site Review:

RECORD STORAGE
During the site review, the auditor must:

Risk Screening Process:

o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected.

Access Control:

o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only.

o Informal conversation with the director reported that investigations are maintained onsite in a locked cabinet in the director's office. The auditor observed the locked cabinet. Additionally, a copy is held offsite with the agency PREA coordinator.

Interviews

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

Corrective Actions:

· Retrain Investigation staff on having more detail in narrative, such as what was reviewed aside from interviews. For example, if the incident occurred in the courtyard was the camera monitoring system reviewed. Also, resident and staff should both sign notification forms not just state on form verbally notified.

	Corrective Action Implemented: The facility provided documentation where staff was retrained in the process. Documentation of the training provided along with the roster (5 staff). No further action is required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (h). Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigation Report: There were zero reported criminal investigations. Interviews Investigative Staff: Criminal investigations referred to law enforcement and DHR are retained in the client's file. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (i). Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, there were zero substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20,2012, or since the last PREA audit. · The number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012, or since the last PREA audit, whichever is later: 0. Interviews Investigative Staff: The interviewed staff reported that cases are referred to prosecution when an investigation reveals the incident may be criminal in nature. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (j). The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ the agency retains all written reports pertaining to administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “the SART will maintain investigative records of alleged sexual abuse or harassment as long as the alleged abuser is incarcerated or employed by Pathway plus five years” (p. 19). · Investigation Reports: All reported allegations were investigated. There were no allegations involving a staff member who departed the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (k). The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Investigative Staff: If a staff member alleges to have committed sexual abuse or sexual harassment terminates employes the investigation continues regardless of if her or she is still employed. Corrective Actions: N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.371 (l). Auditor is not required to audit this provision. 115.371 (m). When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Director: When an outside agency investigation, the facility would stay informed by staying in contact with the investigator. We would contact regularly for updates. PREA Coordinator - The interviewed PREA Coordinator reported that we would ensure we have appropriate contact information for the investigator and ensure they have our contact information as well. We would make contact with them regularly for updates regarding our clients. PREA Compliance Manager – The interviewed staff reported that if an outside agency investigates an allegation, they will contact the investigators and DHR case workers in order for the facility to request updates. Investigative Staff: If an outside agency conducts an investigation, the investigator and the director will maintain regular contact with the outside agency to ensure updated information is provided and to keep the victim updated as well. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility will enter corrective action to address concerns regarding the investigative process. The corrective actions were completed and follow-up reviewed confirmed that the corrective action items were implemented and corrected. With these measures in place, the initial audit findings are resolved, and the facility is compliant with the provisions of the standard.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Investigations - 3 2. Interviews: a. Investigative staff – 2 3. Retrain Investigation Staff Material and Roster (5) Findings (By Provision): 115.372 (a). The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ, that the agency imposes a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: Sexual Abuse: When allegations of sexual abuse/assault are made, the following shall happen: Contact local authorities immediately, if a client/resident reports a sexual assault. If the PREA Compliance Manager or PREA Coordinator is available, he/she shall take responsibility for contacting authorities. If the PREA Compliance Manager is not available, on duty staff must contact authorities without delay. If the allegations or quality of evidence suggest a crime has been committed, no further interview of the victim or perpetrator will be conducted until cleared to do so by prosecuting authority.

	Pathway will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. If there is a possibility of new physical evidence to be used: Secure the area where the alleged abuse took place and do not allow residents to enter the area until police personnel have cleared the area; Do not touch anything in the area where the alleged abuse took place other than to preserve the life or safety of an individual; Move the alleged victim to a secure area until authorities arrive; If conditions allow, direct the alleged perpetrator to remain in an area where they can be observed until authorities arrive; Pathway staff shall cooperate with all aspects of the investigation by local authorities. The PREA Compliance Manager and PREA Coordinator shall endeavor to remain informed about the progress of the investigation and notify all program licensing authorities; Pathway's PREA Compliance Manager/designee or PREA Coordinator shall conduct administrative investigation; Any substantiated allegations of conduct that appears criminal will be referred for prosecution (p. 20). · Investigations: documentation of administrative findings were reviewed for proper standard of proof. The investigation report document has limited information on how the findings were determined. Interviews Investigative Staff: In general, the standard of evidence require substantiate allegations of sexual abuse or sexual harassment, is that no greater than a preponderance of evidence. Corrective Actions: · Investigations: Upon review the auditor determined that the facility needs additional training on completing a thorough investigation. A thorough investigation shall include items such as evidence supporting on refuting the allegations along with statements. If there are no allegations during the corrective action period, the facility shall conduct a tabletop exercise on completing an entire investigation. Next steps: training and tabletop exercise. Due Date: 11/30/2024 Corrective Action Implemented: The facility provided documentation where staff was retrained in the process. Documentation of the training provided along with the

	roster (5 staff). No further action is required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The facility has corrective action to address the thoroughness of an investigation. The corrective actions were completed and follow-up reviewed confirmed that the corrective action items were implemented and corrected. With these measures in place, the initial audit findings are resolved, and the facility is compliant with the provisions of the standard.

115.373	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Investigations (3) 2. Interviews: a. Director b. Investigative staff - 2 Findings (By Provision): 115.373 (a). Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: · As reported in the PAQ, the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility in the past 12 months: 0. Of the alleged sexual abuse investigations that were completed in the past 12 months, the number of residents who were notified, verbally or in writing, of the results of the investigation: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that Reporting to Clients/Residents: In the event of a client/resident allegation of sexual abuse, the PREA Compliance Manager shall: Following an investigation into a client/resident's allegation that he/she suffered sexual abuse in Pathway's facility, the PREA Compliance Manager shall inform the client/resident, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. o If the Pathway did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the client/resident. o Following a client's/resident's allegation that he/she was sexually abused by another client/resident, Pathway will inform the alleged victim when: o Pathway learns that the alleged abuser has been indicted on a charge related to the sexual abuse; o Pathway learns that the alleged abuser has been convicted on a charge related to the sexual abuse. o Following a client/resident's allegation that a staff member has committed sexual abuse against the client/resident and the findings are substantiated or unsubstantiated; the PREA Compliance Manager shall inform the client/resident whenever: o The staff member is no longer employed at the facility; o The staff is no longer posted within the client’s team o The agency learns that the staff member has been indicted on a charge related to the sexual abuse within the facility; o The agency learns that the staff member has been convicted on a charge related to the sexual abuse within the facility. o All such notifications or attempted notifications shall be documented by the PREA Compliance Manager.

	o The PREA Compliance Manager's obligation to report shall terminate if the client/ resident is released from Pathway's program. o The departure of the alleged victim from the program or alleged abuser from employment or control of the program or agency shall not provide basis for terminating an investigation (pp.20-21). · There were no notifications as all allegations were sexual harassment. Interviews Director: Upon completion of the investigation, reporters are made aware of the outcome of the investigation. Investigative Staff: The interviewed investigator reported that residents are notified of the results of the investigation. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.373 (b). If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months: 0. Of the outside agency investigations of alleged sexual abuse that were completed in the past 12 months, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigation: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “if the Pathway did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the client/resident” (p. 21). · Investigation Reports: Upon review of investigation reports there were no outside entity conducted investigations. · There were no notifications as all allegations were sexual harassment.

	Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.373 (c). Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever: (1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that following a resident’s allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency has determined that the allegation is unfounded) whenever: • The staff member is no longer posted within the resident’s unit; • The staff member is no longer employed at the facility; • The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or • The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. There has been zero substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in an agency facility in the past 12 months. While there were zero reported allegations of sexual abuse, the facility has a form (PREA Post Investigation Resident Notification) to notify residents of the results of the sexual abuse allegation. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that Following a client/resident's allegation that a staff member has committed sexual abuse against the client/resident and the findings are substantiated or unsubstantiated; the PREA Compliance Manager shall inform the client/resident whenever: The staff member is no longer employed at the facility; The staff is no longer posted within the client’s team The agency learns that the staff member has been indicted on a charge related to the sexual abuse within the facility; The agency learns that the staff member has been convicted on a charge related to the sexual abuse within the facility (p. 4).

	Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.373 (d). Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: (1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or (2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that following a resident’s allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: • The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or • The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. There were no reported allegations of sexual abuse. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: Following a client's/resident's allegation that he/she was sexually abused by another client/resident, Pathway will inform the alleged victim when: Pathway learns that the alleged abuser has been indicted on a charge related to the sexual abuse; Pathway learns that the alleged abuser has been convicted on a charge related to sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.373 (e). All such notifications or attempted notifications shall be documented. Compliance Determination: The facility has demonstrated compliance with provision of this standard because:

	· As reported in the PAQ, the facility has a policy that all notifications to residents described under this standard are documented. In the past 12 months, the number of notifications to residents that were provided pursuant to this standard: 0. Of those notifications made in the past 12 months, the number that were documented: 0 · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “all such notifications or attempted notifications shall be documented by the PREA Compliance Manager” (p. 21). · While there were zero reported allegations of sexual abuse, the facility has a form (PREA Post Investigation Resident Notification) to notify residents of the results of the sexual abuse allegation. · Upon review of the investigations there were no reported allegations of sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.373 (f). The auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.376	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual

	Findings (By Provision): 115.376 (a). Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment policies. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that DISCIPLINE: It is the policy of Pathway that all staff will be subject to disciplinary sanctions up to and including termination for violating the sexual harassment and sexual abuse policies. o Staff that have engaged in sexual abuse, sexual coercion, or sexual harassment will be terminated from Pathway. o Disciplinary sanctions for violating the sexual abuse or sexual harassment policy but not for actually engaging in sexual abuse will be based on the following: o The nature and circumstances of the acts committed. o The staff member's disciplinary history. o The sanctions imposed for similar offenses by other staff with similar histories. o All staff, contractor, and volunteer terminations or resignations resulting from criminal sexual abuse will be referred to law enforcement. o All contractors and volunteers who violate Pathway's sexual abuse and/or sexual harassment policies will be prohibited from further contact with clients/residents. Where applicable, law enforcement and licensing agencies will be notified. Pathway will take appropriate remedial measures and consider whether to prohibit further contact with clients/residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. o Clients/residents will be subject to disciplinary sanctions through a formal disciplinary process following; o An administrative finding that the client/resident engaged in client/resident - on - client/resident sexual abuse or sexual harassment. o Following a criminal finding of guilt for client/resident - on - client/resident sexual abuse or sexual harassment. o Sexual abuse/assault/harassment/coercion are serious misconduct violations for

clients/residents in Pathway's program. Any form of such sexual behavior will result in termination from the program.

o In the event a disciplinary sanction for resident-on-resident sexual abuse results in the isolation of a resident, Pathway will follow the protocol for isolation (see Section IV, number 13).

o Pathway offers therapy, counseling and other interventions designed to address and correct the underlying reasons or motivations for abuse, in the event the alleged abuser remains in the program.

o Pathway will consider whether to require the offending client/resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general programming or education is not conditional on participation in such interventions.

o A client/resident's report of sexual abuse made in good faith and based on reasonable belief will not be disciplined for falsely reporting an incident, even if the investigation does not establish evidence sufficient to substantiate the allegation.

o Pathway will discipline a client/resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

o Pathway prohibits all sexual activity between clients/residents. As such, Pathway will discipline residents for such activity. Pathway deems such activity to constitute sexual abuse only if it determines that the activity is coerced (p. 23).

· There were no reported allegations that involve staff disciplinary measures.

Corrective Actions:

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

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

115.376 (b). Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

Compliance Determination:

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

· Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. In the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies: 0. In the past 12 months, the number of staff from the facility who have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: 0.

	· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that DISCIPLINE: It is the policy of Pathway that all staff will be subject to disciplinary sanctions up to and including termination for violating the sexual harassment and sexual abuse policies. Staff that have engaged in sexual abuse, sexual coercion, or sexual harassment will be terminated from Pathway. Disciplinary sanctions for violating the sexual abuse or sexual harassment policy but not for actually engaging in sexual abuse will be based on the following: The nature and circumstances of the acts committed. The staff member's disciplinary history. The sanctions imposed for similar offenses by other staff with similar histories. All staff, contractor, and volunteer terminations or resignations resulting from criminal sexual abuse will be referred to law enforcement. All contractors and volunteers who violate Pathway's sexual abuse and/or sexual harassment policies will be prohibited from further contact with clients/residents. Where applicable, law enforcement and licensing agencies will be notified. Pathway will take appropriate remedial measures and consider whether to prohibit further contact with clients/residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Clients/residents will be subject to disciplinary sanctions through a formal disciplinary process following; An administrative finding that the client/resident engaged in client/resident - on - client/resident sexual abuse or sexual harassment. Following a criminal finding of guilt for client/resident - on - client/resident sexual abuse or sexual harassment. Sexual abuse/assault/harassment/coercion are serious misconduct violations for clients/residents in Pathway's program. Any form of such sexual behavior will result in termination from the program. In the event a disciplinary sanction for resident-on-resident sexual abuse results in the isolation of a resident, Pathway will follow the protocol for isolation (see Section IV, number 13). Pathway offers therapy, counseling and other interventions designed to address and correct the underlying reasons or motivations for abuse, in the event the alleged abuser remains in the program. Pathway will consider whether to require the offending client/resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general

	programming or education is not conditional on participation in such interventions. A client/resident's report of sexual abuse made in good faith and based on reasonable belief will not be disciplined for falsely reporting an incident, even if the investigation does not establish evidence sufficient to substantiate the allegation. Pathway will discipline a client/resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. Pathway prohibits all sexual activity between clients/residents. As such, Pathway will discipline residents for such activity. Pathway deems such activity to constitute sexual abuse only if it determines that the activity is coerced (p. 23). · There were no reported allegations that involve staff disciplinary measures. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.376 (c). Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According to the PAQ, the disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. In the past 12 months, the number of staff from the facility who have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse): 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that Disciplinary sanctions for violating the sexual abuse or sexual harassment policy but not for actually engaging in sexual abuse will be based on the following: o The nature and circumstances of the acts committed. o The staff member's disciplinary history.

	o The sanctions imposed for similar offenses by other staff with similar histories (p. 22). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.376 (d). All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According to the PAQ, all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “All staff, contractor, and volunteer terminations or resignations resulting from criminal sexual abuse will be referred to law enforcement.” (p. 22). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.377	**Corrective action for contractors and volunteers**

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual

2. Interviews:

a. Director

Findings (By Provision):

115.377 (a). Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

Compliance Determination:

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

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

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “All staff, contractor, and volunteer terminations or resignations resulting from criminal sexual abuse will be referred to law enforcement. All contractors and volunteers who violate Pathway's sexual abuse and/or sexual harassment policies will be prohibited from further contact with clients/residents. Where applicable, law enforcement and licensing agencies will be notified. Pathway will take appropriate remedial measures and consider whether to prohibit further contact with clients/residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer (p 22).

· There were no allegations that involved volunteers or contractors.

Corrective Actions:

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

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

115.377 (b). The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Compliance Determination:

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

· As reported in the PAQ the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “All staff, contractor, and volunteer terminations or resignations resulting from criminal sexual abuse will be referred to law enforcement. All contractors and volunteers who violate Pathway's sexual abuse and/or sexual harassment policies will be prohibited from further contact with clients/residents. Where applicable, law enforcement and licensing agencies will be notified. Pathway will take appropriate remedial measures and consider whether to prohibit further contact with clients/residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer (p 22).

· There were no allegations that involved volunteers or contractors.

Interviews

Director: Contractors or volunteers would not be allowed on the premises if they violated the agency sexual abuse or sexual harassment policy. We would continue our procedure to refer to local law enforcement and DHR.

Corrective Actions:

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

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

Overall Findings:

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

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Investigation Reports/Data Collection Report 2. Interviews: a. Director b. Medical and mental health staff (1) Findings (By Provision): 115.378 (a). A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, there were no reported residents subject to disciplinary sanctions following an administrative finding that the resident engaged in resident-on-resident sexual abuse, following a criminal finding of guilt for resident-on-resident sexual abuse. In the past 12 months, the number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: 0. In the past 12 months, the number of criminal findings guilty of resident-on-resident sexual abuse that have occurred at the facility: 0.

	· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Clients/residents will be subject to disciplinary sanctions through a formal disciplinary process following; An administrative finding that the client/resident engaged in client/resident - on - client/resident sexual abuse or sexual harassment. Following a criminal finding of guilt for client/resident - on - client/resident sexual abuse or sexual harassment (pp. 22). · Although there were no incidents of sexual abuse the auditor verified that the site documents disciplinary actions on the data collection form attached to the investigation process. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.378 (b). Per the PAQ, in the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. It was also reported in the PAQ that in the event a disciplinary sanction for resident-on-resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible. In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse: 0. In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: 0 In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse who were denied access to other programs and work opportunities: 0. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Per the PAQ, in the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. It was also reported in the PAQ that in the event a disciplinary sanction for resident-on-resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible. In the past 12

	months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse: 0. In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: 0. In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse who were denied access to other programs and work opportunities: 0. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “In the event a disciplinary sanction for resident-on-resident sexual abuse results in the isolation of a resident, Pathway will follow the protocol for isolation (see Section IV, number 13)” (p. 23). · Although there were no incidents of sexual abuse the auditor verified that the site documents disciplinary actions on the data collection form attached to the investigation process. Interviews Director: The interviewed staff reported that any criminal findings of abuse would result in an unsuccessful discharge from the program or adding time to treatment. We would look at the circumstances and client’s history and ensure consequences are appropriate to the situation and follow with other similar offenses by other clients. We would consider any mental illness or disability. However, regardless of disability or illness, safety would remain a priority; therefore, the clients posed a substantial risk to others would be unsuccessfully discharged from the program. Isolation would not be used as a disciplinary sanction. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.378 (c). The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The facility has demonstrated compliance with this provision of the standard because: · Although there were no incidents of sexual abuse the auditor verified that the site documents disciplinary actions on the data collection form attached to the investigation process. Interviews Director: The interviewed staff reported that any criminal findings of abuse would

	result in an unsuccessful discharge from the program or adding time to treatment. We would look at the circumstances and client's history and ensure consequences are appropriate to the situation and follow with other similar offenses by other clients. We would consider any mental illness or disability. However, regardless of disability or illness, safety would remain a priority; therefore, the clients posed a substantial risk to others would be unsuccessfully discharged from the program. Isolation would not be used as a disciplinary sanction. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.378 (d). If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. It was further reported that if the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for the abuse, the facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general programming or education is not conditional on participation in such interventions. Interviews Medical and Mental Health Staff: The interviewed staff reported that therapy, counseling, or other intervention services are offered to all residents. Participation in the services is not a requirement of the rewards-based behavior management system, programming, or education. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility is fully compliant with this provision. 115.378 (e). The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility disciplines resident for sexual contact with staff only upon finding that the staff member did not, consent to such contact. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway will discipline a client/resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact” (p. 23). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.378 (f). For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “A client/resident's report of sexual abuse made in good faith and based on reasonable belief will not be disciplined for falsely reporting an incident, even if the investigation does not establish evidence sufficient to substantiate the allegation” (p. 23). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility is fully compliant with this provision. 115.378 (g). An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility prohibits sexual activity between residents. In addition, the agency prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Pathway prohibits all sexual activity between clients/ residents. As such, Pathway will discipline residents for such activity. Pathway deems such activity to constitute sexual abuse only if it determines that the activity is coerced” (p. 23). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.381	**Medical and mental health screenings; history of sexual abuse**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual

c. Follow Up Services/Individual Session (1)

2. Staff responsible for risk screening - 1

d. Medical and Mental Health staff - 1

e. Residents who disclosed prior sexual victimization-2

Findings (By Provision):

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

Compliance Determination:

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

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

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Clients/residents who disclose any prior sexual victimization or perpetration during the vulnerability assessment are offered a follow-up meeting with a medical, where appropriate, or mental health practitioner within 14 days of the admission screening. These meetings are documented in the client/resident’s chart” (p. 13).

· Follow up-Individual Session: the auditor was able to review documentation of a resident who disclosed prior victimization. The therapist documented the follow up meeting on an individual session note. The notes are secured in a password protected electronic file.

Interviews

Staff Responsible for Risk Screening: The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community,

	consultation will occur with the director to determine necessary treatment services. Residents(s) in custody who Disclose Sexual Victimization at Risk Screening: Two onsite resident in custody disclosed previous sexual victimization during the audit period. One resident stated that the staff followed up with them and they notified staff that they previously went to outpatient services. The resident further reported that the allegation is still being investigated. One resident denied reporting any prior history of sexual victimization. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.381 (b). If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As indicated in the PAQ, all residents who have ever previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. In the past 12 months, the percentage of residents who previously perpetuated sexual abuse, as indicated during screening, who were offered a follow up meeting with a mental health practitioner: 100. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Clients/residents who disclose any prior sexual victimization or perpetration during the vulnerability assessment are offered a follow-up meeting with a medical, where appropriate, or mental health practitioner within 14 days of the admission screening. These meetings are documented in the client/resident’s chart” (p. 13). · The auditor did not identify any files of residents who exhibited prior perpetration. Interviews Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has previously perpetrated sexual abuse, whether in an institutional setting or in the community, the clinical director to determine next steps and treatment services. Corrective Actions: N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.381 (c). Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As reported in the PAQ, information related to sexual victimization or abusiveness that occurred in an institutional setting is not strictly limited to medical and mental health practitioners. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “To ensure confidentiality and sensitivity of information of the client's/resident's responses on the assessment, assessment information will be kept in the client's/resident's confidential file. However, communication will be disseminated to staff regarding a client’s overall risk of victimization or risk of perpetrating a violent or sexual act. This will include only the clinician’s assessment of risk, information specific to the client’s history. Screening information shall be used to determine rooming assignments with the goal of keeping separate those clients/residents at high risk of being sexually victimized from those at high risk of being sexually abusive (p. 12). · The mental health sessions are documented in a secure password protected electronic case management system. Access to components of the system is based on your position and roll in the agency. Access to mental health notes is limited to the leadership staff and the mental health staff. Site Review: RECORD STORAGE Risk Screening Process: o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected. Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only. The electronic data system is password protected.

	o Informal conversation with the director reported that investigations are maintained onsite in a locked cabinet in the director's office. The auditor observed the locked cabinet. Additionally, a copy is held offsite with the agency PREA coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.381 (d). Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting unless the resident is under the age of 18. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 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. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway staff will obtain informed consent to report information regarding sexual victimization that did not occur in an institution setting, unless the client/resident is under the age of 18" (p. 13). Interviews Medical and Mental Health Staff: Prior to reporting sexual abuse, medical and mental health staff will speak to the resident about informed consent. This process is discussed at intake. Additionally, we notify them of the duty to report. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual 2. Interviews: a. Medical and mental health staff (1) b. Random Sample of Staff/Security staff and non-security staff first responders (8) Findings (By Provision): 115.382 (a). Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. It further stated that the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgement. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Forensic medical examinations in the community will be provided free of charge to the victim. The victim will be provided with unimpeded access to emergency and crisis intervention services, which will also be provided free of charge to the victim. SANE Nurses are located at USA Women’s and Children’s Hospital. In the event that a SANE is unavailable, a forensic medical examination will be provided by a qualified medical practitioner” (p. 9).

	· There were no allegations of sexual abuse reported during the audit time frames. Interviews Medical and Mental Health Staff: If a resident reports sexual abuse they receive timely and unimpeded access to emergency medical treatment and/or crisis intervention services. This is done immediately, and the staff will notify the supervisor immediately. The nature and scope of such services are determined according to professional judgment. Medical staff is on call 24/7. Services are rendered immediately upon notification. Resident who Reported Sexual Abuse: There were no residents during the onsite audit that reported an allegation of sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.382 (b). If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · There were no allegations of sexual abuse reported during the audit time frames. Interviews Random Sample of Staff: Eight random staff interviewed reported being aware of the agency procedure for reporting any information related to an individual in custody who may be at imminent risk of sexual abuse or sexual harassment. All interviewed staff articulately they would immediately notify the supervisor, separate the residents, and make sure the area is secure. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: Corrective Actions: N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.382 (c). Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Interviewed medical and mental health staff reported that such services are addressed immediately. · There were no allegations of sexual abuse reported during the audit time frames. Interviews Medical and Mental Health Staff: The interviewed staff reported that victims of sexual abuse are offered timely information about access to emergency contraception and sexual transmitted infection prophylaxis. Medical will coordinate services immediately upon being notified. Anytime medical services are needed they will respond within 10 minutes. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.382 (d). Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the treatment services provided to every victim is without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out the incident. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures

	Manual states that “Treatment services shall be provided to the alleged victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident” (p. 24). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.383	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual 2. Interviews: a. Medical and Mental Health staff (1) Findings (By Provision): 115.383 (a). The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ, the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: MEDICAL AND MENTAL CARE: It is the intention of Pathway that there will be no long-term forfeiture of services for victims of sexual abuse, sexual coercion, sexual harassment, or sexual solicitation. Recognizing that the safety of the victim is paramount, room assignments will be taken into consideration. Medical access to services for victims of sexual abuse will be handled in the community. · Timely, unimpeded access to emergency medical treatment without financial cost, as determined by the medical practitioners' professional judgment. All services, or attempts to provide services, will be documented. · Timely access to testing and prophylactic treatment for sexually transmitted diseases and infections, in accordance with professionally accepted standards of care, where medically appropriate. · Communication with community sexual abuse advocate regarding any information deemed not confidential. Mental health services for victims of sexual abuse will be referred to their therapist for: · Timely, unimpeded access to appropriate mental health evaluation services without financial cost as determined by the therapist's professional judgment. · Comprehensive information of limits of confidentiality and duty to report. · Completion of a mental health evaluation Treatment services shall be provided to the alleged victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Ongoing Medical Care Pathway shall offer medical and mental health evaluation and, as appropriate, treatment to all clients who have been victimized by sexual abuse in any lockup or juvenile facility. · Evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

	· Pathway shall provide such victims with medical and mental health services consistent with the community level of care. · Client victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. · If pregnancy results from conduct specified in number four of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. · Client victims of sexual abuse while incarcerated shall be offered continued tests for sexually transmitted infections as medically appropriate. · Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. · Pathway shall attempt to conduct a mental health evaluation of all known client-on-client abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 185.383 (b). The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · There were no allegations of sexual abuse reported during the audit time frames. Interviews Medical and Mental Health Staff: The interviewed staff reported that evaluation and treatment of residents who have been victimized entails the patient being evaluated by staff and we will determine services needed. This may include a medical assessment or individual therapy. Residents who reported a sexual abuse: There were no residents who reported sexual abuse.

	Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.383 (c). The facility shall provide such victims with medical and mental health services consistent with the community level of care. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported by the interviewed medical and mental health staff, the treatment and services provided are consistent with the community level of care. Interviews Medical and Mental Health Staff: The interviewed staff reported that medical treatment and services is consistent with the community level of care. We meet with the residents individually two times per week and group therapy every week. Medical services are available 24/7. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.383 (d). Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The site does not house female residents. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.383 (e). Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because:

	· The site does not house female residents. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.383 (f). Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “client victims of sexual abuse while incarcerated shall be offered continued tests for sexually transmitted infections as medically appropriate” (p. 24). Interviews Residents who reported a sexual abuse: There were no residents who reported sexual abuse. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.383 (g). Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Treatment services shall be provided to the victim without

financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident" (p. 24).

Interviews

Residents who reported a sexual abuse: There were no residents who reported sexual abuse.

Corrective Actions:

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

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

115.383 (h). The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Compliance Determination:

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

· As reported in the PAQ, the facility, attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. Upon admission all juveniles will receive a mental health assessment by a professional mental health provider for the purpose of identifying suicidal tendencies, sexual abuse victimization and predatory risk to other residents.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "Pathway shall attempt to conduct a mental health evaluation of all known client-on-client abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners (p. 24).

Interviews

Medical and Mental Health Staff: Mental Health evaluations are conducted on all resident-on-resident abusers. All assessments are done immediately upon intake and reassessed if something happens.

Corrective Actions:

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

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

Overall Findings:

	The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Upon completion of the medical interview, the facility will be compliant with the standard.

115.386	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Incident Review (3) 2. Interviews: a. Director b. Incident review team c. PREA Compliance Manager Findings (By Provision): 115.386 (a). The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The facility provided a

document that shows how an incident review debriefing would be documented.

· In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents: 0.

· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Sexual abuse incident reviews will be conducted: A review team will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. This will be done within 30 days of the conclusion of the initial investigation” (pp. 24-25).

· While the facility did not have any sexual abuse allegations, there were three incident reviews conducted on sexual harassment allegations. All incident reviews were completed immediately upon the conclusion of the investigation.

Corrective Actions:

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

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

115.386 (b). Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

Compliance Determination:

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

· The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.

· In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility were followed by a sexual abuse incident review within 30 days, excluding only "unfounded" incidents: 0.

· While the facility did not have any sexual abuse allegations, there were three incident reviews conducted on sexual harassment allegations. All incident reviews were completed immediately upon the conclusion of the investigation.

Interviews

PREA Compliance Manager: The interviewed staff reported that they participate in the incident reviews. The data from the meeting is sent to the PREA Coordinator. My role is as a site director and a PCM. We will monitor trends, and if action is needed, we will address any findings and resolve the issue.

	Incident Review Team: The interviewed staff on the incident review team reported that the team will consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.386 (c). The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “The review team shall include the Director, PREA Compliance Manager, Human Resources staff member, and Senior Shift Leader Supervisor, with input from Shift Leaders and therapists” (p. 25). · While the facility did not have any sexual abuse allegations, there were three incident reviews conducted on sexual harassment allegations. All incident reviews were completed immediately upon the conclusion of the investigation. Interviews: Director: The facility has a sexual abuse incident review team; which includes upper-level management. The team consists of the Program Director, Campus Coordinator, and Senior Shift Leader. The PREA Compliance Manager is also the Director. Corrective Actions: N/A. There are no corrective actions for this provision Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.386 (d). The review team shall: (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect,

	or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1) -(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Compliance Manager. · Sexual Abuse Critical Incident Review Form. The form takes the following into consideration: 1. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to Sexual Abuse; 2. Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics within the program; 3. Discuss the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; 4. Assess the adequacy of staffing levels in that area during different shifts; 5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and 6. Determine whether the facility implemented the recommendation for improvement. Interviews: Director: The team does an incident review, the information collected is used to evaluate for potential warning signs that were missed, corrective action that needs

	to occur including staff trainings, policy changes, or changes to procedures. The review team considers all of the above areas mentioned. PREA Compliance Manager: The interviewed staff reported that all incidents are reviewed through the process. Actions are taken to address any problems. Incident Review Team: The interviewed staff on the incident review team reported that the team will consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The incident review team examines all areas where abuse has been reported and looks for physical barriers that might enable abuse. The review team will assess staff levels, look for deficiencies, and look to see if staff are present and aware. The incident review team assesses whether additional, cameras are needed in certain areas. Cameras are evaluated on whether they need to be repositioned. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.386 (e). The facility shall implement the recommendations for improvement or shall document its reasons for not doing so. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ, that the facility implements the recommendations for improvement or documents its reasons for not doing so. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that: o The review team shall: § Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; § Consider any potential motivators of the incident or allegations; § Examine the area where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; § Assess the adequacy of staffing levels during different shifts · Assess whether monitoring technology should be augmented to supplement

	supervision § Prepare a report of its findings and any recommendations for improvement and submit such report to the CEO and PREA Compliance Manager. § Recommendations for improvement shall be implemented, or reasons for not doing so will be documented (pp. 25-26). · While the facility did not have any sexual abuse allegations, there were three incident reviews conducted on sexual harassment allegations. All incident reviews were completed immediately upon the conclusion of the investigation. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.387	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Data Collection Instrument (3 investigations) Findings (By Provision): 115.387 (a). The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “A standardized instrument will be utilized for the purpose of data collection to ensure uniform data from every allegation of sexual abuse and sexual harassment is collected. This instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice” (p. 24). · The data collection instrument completed on the investigations is a tool utilized to collect uniform data on allegations. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.387 (b). The agency shall aggregate the incident-based sexual abuse data at least annually. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency aggregates incident-based sexual abuse data annually. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.387 (c). The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ the facility uses a standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that "A standardized instrument will be utilized for the purpose of data collection to ensure uniform data from every allegation of sexual abuse and sexual harassment is collected. This instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice" (p. 24). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.387 (d). The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that Pathway will maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews" (p. 24). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.387 (e.) N/A the agency does not contract for the confinement of its residents and skip to 115.387 (f).). It was further reported that the data from private facilities complies with SSV reporting regarding content. 115.387 (f). Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has not been required to provide the Department of Justice (DOJ) with data from the previous calendar year. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.388	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Website d. 2024 Annual Report-pending 2. Interviews: a. Agency head b. PREA coordinator c. PREA Compliance Manager

	Findings (By Provision): 115.388 (a). The agency shall review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: (1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency reviews data collected and aggregated pursuant 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including: · Identified problem areas; · Taking corrective action on an ongoing basis; and · Preparing an annual report of its findings from its data review and corrective actions for each facility, as well as the agency as a whole. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that the facility will “Ensure that annual reviews include inspection for areas and situations where sexual abuse may be likely to occur and recommend mitigation for those areas and situations. Corrective action will be taken on an ongoing basis. Produce an annual summary for the Chief Executive Officer that provides an assessment of Pathway’s progress in addressing sexual abuse. The annual report shall include the frequency and severity of sexual abuse/sexual harassment within Pathway's facilities including trends during the year, comparisons to previous years, deficiencies identified in the annual report, and corrective action from the previous year’s report. The annual report will be available through Pathway’s website” (p. 25). · The facility opened in October 2023. The first annual report was completed in October 2024. Interviews Agency Head: The interviewed agency head reported that incident based sexual abuse data is used to assess and improve problem areas or other issues are identified and corrective action is taken as needed. After every allegation, problem areas or other issues are identified, and corrective action is taken if needed. PREA Coordinator: The interviewed PREA Coordinator reported that all data is completed. All data is filed in the office of the PREA Coordinator. Only select

	administrative staff have access to this area. The collected data is reviewed annually to ensure that no data is due to be terminated. Upon review of each PREA related incident, any identified areas of concern are addressed through corrective action. T the data is reviewed yearly and compiled into a yearly report. This report looks at trends for each facility and compares the data from the current year to the previous. The report includes any corrective action taken. It is approved by the CEO and placed on Pathway, Inc's website. PREA Compliance Manager: The interviewed staff reported that data is collected, and reports made along with the annual reports are kept in a confidential file. The data is sent to the PREA Coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.388 (b). Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the annual report indicates a comparison of the current year's data and corrective actions to those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that the facility will "Produce an annual summary for the Chief Executive Officer that provides an assessment of Pathway's progress in addressing sexual abuse. The annual report shall include the frequency and severity of sexual abuse/sexual harassment within Pathway's facilities including trends during the year, comparisons to previous years, deficiencies identified in the annual report, and corrective action from the previous year's report. The annual report will be available through Pathway's website" (p. 25). · The facility opened in October 2023. The first annual report was completed in October 2024. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

	115.388 (c). The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency makes its annual report readily available to the public, at least annually, through its website. The agency PREA reports are found at: https://www.pathway-inc.com/copy-of-services. Interviews Agency Head: The interviewed agency head reported that they approve the agency annual reports. Annual reports are completed after review of the data collected for the year to identify trends and corrective action that may be necessary. These reports are provided to the CEO for review and published on our website. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.388 (d). The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. In addition, the agency indicates the nature of material redacted. · The facility opened in October 2023. The first annual report was completed in October 2024. Interviews PREA Coordinator: The interviewed PREA Coordinator reported that any personal identifying information of staff or clients would be redacted; however, to date no material has been redacted from our annual reports. If material were redacted, we would indicate the nature of that material.

	Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.389	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual c. Website: https://www.pathway-inc.com/copy-of-services. 2. Interviews: a. PREA coordinator Findings (By Provision): 115.389 (a). The agency shall ensure that data collected pursuant to § 115.387 are securely retained. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that incident-based and aggregate data is securely retained.

	· Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Data collected will be securely retained for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise” (p. 26). Site Review: RECORD STORAGE Risk Screening Process: o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected. Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only. The electronic data system is password protected. o Informal conversation with the director reported that investigations are maintained onsite in a locked cabinet in the director’s office. The auditor observed the locked cabinet. Additionally, a copy is held offsite with the agency PREA coordinator. § Interviews PREA Coordinator: The interviewed PREA Coordinator reported that all data is filed in the office of the PREA Coordinator. Only select administrative staff have access to this area. The collected data is reviewed annually to ensure that no data is due to be terminated. Upon review of each PREA related incident, any identified areas of concern are addressed through corrective action. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.389 (b). The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website. · Policy: Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that the facility will “Produce an annual summary for the Chief Executive Officer that provides an assessment of Pathway’s progress in addressing sexual abuse. The annual report shall include the frequency and severity of sexual abuse/sexual harassment within Pathway's facilities including trends during the year, comparisons to previous years, deficiencies identified in the annual report, and corrective action from the previous year’s report. The annual report will be available through Pathway’s website” (p. 25). · Website: https://www.pathway-inc.com/copy-of-services. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.389 (c). Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. · A review of the agency website did not have any personal identifiers. All personal identifiers were removed from the Annual report. Website: https://static1.squarespace.com/static/598b3628197aea4997aafcfb/t/661d88db102fad5a6f89a545/1713211611368/115.387+PREA+Data+Report+-+Comparison.pdf Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.389 (d). The agency shall maintain sexual abuse data collected pursuant to §

	115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. The agency complies with this provision by maintaining at least 10 years of initial data collection. · Policy: The Pathway, Inc. Prison Rape Elimination Act (PREA) Policy and Procedures Manual states that “Data collected will be securely retained for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise” (p. 26). · Website: https://www.pathway-inc.com/copy-of-services. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: · Website: PATHWAY - Services (pathway-inc.com)) Findings (By Provision):

	115.401 (a). During the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · A review of the agency's website provided PREA audit reports according to cycles. · The facility PREA reports are included on the agency website. · DYS Annual Inspection Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.401 (b). As reported by the PREA coordinator, the FACILITY is operated by a private entity (Pathways, Inc.), a contractor for Alabama Division of Youth Services. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: A review of the agency's website provided PREA audit reports according to cycles. The facility PREA reports are included on the agency website. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the facility by the Director. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred or deterred entry to any areas. The auditor had the ability to observe freely, with entry provided to all areas without prohibition. Based on review of documentation the facility is compliant with the intent of the provision. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: On the first day of the audit after the entrance conference, the auditor conducted a comprehensive tour of the facility. It was requested that when the auditor pauses to speak to a resident or staff, that staff on the tour please step away so the conversation might remain private. This request was well respected. During the site review the auditor made numerous observations, including the posting of Notices of PREA Audits, PREA Related Posters, and TIP Posters (with phone numbers to call to report any concern or condition), notices advising resident that female staff routinely work in the facility, locations of showers and privacy issues, bathrooms, medical/grievance boxes, requests forms and boxes for requests, configuration of living units, capacities of dorm/bed rooms, observations of blind spots, camera deployment, the use of mirrors to mitigate blind spots, staffing levels, supervision of resident, accessibility to telephones and instructions for using the phones to report sexual abuse, main control room, dayroom, classrooms, etc.. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (i). During the on-site visit, the auditor was provided access to any and all documents requested. All documents requested were received to include, but not limited to employee and resident files, sensitive documents, and investigation reports. Based on review of documentation the facility is compliant with the intent of the provision. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The auditor provided the facility with a documentation checklist. The checklist is organized by standards to help the facility through the pre-audit, onsite and post audit phase and to provide the requested documentation by auditor. The PREA coordinator/compliance manager provided the auditor with all relevant documents as requested. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (m). The auditor provided private rooms throughout the facility to conduct

	resident interviews. The staff staged the residents in a fashion that the auditor did not have to wait between interviews. The rooms provided for resident interviews were soundproof and somewhat visually confidential from other residents who were judged to have provided an environment in which the offenders felt comfortable to openly share PREA-related content during interview. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · During the pre-audit period, the facility received instructions to post the required PREA Audit Notice of the upcoming audit prior to the on-site visit for confidential communications. The facility posted the notices in English and Spanish. The auditor received email and pictures confirming the posted notices and observed the posted notices on-site. · As of October 11, 2024, there was no communication from a resident or staff. Staff interviews indicated that Residents are permitted to send confidential information or correspondence in the same manner as if they were communicating with legal counsel. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (n). Residents were able to submit confidential information via written letters to the auditor PO Box or during the interviews with the auditor. The auditor did not receive any correspondence from the residents of the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The auditor reached out to the following organizations: o National Child Abuse Hotline o Ruth House o Alabama DYS Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

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

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

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	yes
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	yes
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.312 (b)	**Contracting with other entities for the confinement of residents**	

	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)	na
115.313 (a)	**Supervision and monitoring**	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate	yes

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

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

	functions of the facility? (N/A for non-secure facilities)	
115.315 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes
115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	yes
115.315 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status?	yes
	If a resident’s genital status is unknown, does the facility	yes

	determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	
115.315 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
115.316 (a)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including:	yes

	Residents who have speech disabilities?	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	
115.317 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes
115.317	**Hiring and promotion decisions**	

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

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

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

	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.321 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is responsible for investigating allegations of sexual abuse.)	yes
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	na
115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.322 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes
115.331 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents’ right to be free from sexual abuse and sexual harassment	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?	yes

	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes
115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes

115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes
115.332 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.332 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (a)	**Resident education**	
	During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes
115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate	yes

	comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	

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

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

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

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

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

115.342 (c)	**Placement of residents**	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes
115.342 (d)	**Placement of residents**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems?	yes
115.342 (e)	**Placement of residents**	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes
115.342 (f)	**Placement of residents**	
	Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when	yes

	making facility and housing placement decisions and programming assignments?	
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	na
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	na
115.342 (i)	**Placement of residents**	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes
115.351 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.351 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private	yes

	entity or office that is not part of the agency?	
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	yes
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes
115.352 (b)	**Exhaustion of administrative remedies**	

	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	yes
115.352 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
115.352 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	yes
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes
115.352 (e)	**Exhaustion of administrative remedies**	

	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	yes
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	yes
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	yes
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	yes
115.352 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	yes

	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.352 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	yes
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

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

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

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

	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes
115.367 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?	yes
115.367 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report	yes

	of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes

115.371 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
115.371 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.371	**Criminal and administrative agency investigations**	

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

	does not provide a basis for terminating an investigation?	
115.371 (m)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.372 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes
115.373 (c)	**Reporting to residents**	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency	yes

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

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

115.378 (a)	**Interventions and disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes
115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	yes

	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	For the purpose of disciplinary action, does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.378 (g)	**Interventions and disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes
115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	

	Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?	yes
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?	yes
115.382 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.382 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?	yes
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.382 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial	yes

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	na
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)	na
115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or	yes

	cooperates with any investigation arising out of the incident?	
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.386 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes

	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.387 (c)	**Data collection**	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.387 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.387 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for	na

	the confinement of its residents.)	
115.387 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	na
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.388 (b)	**Data review for corrective action**	
	Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse?	yes
115.388 (c)	**Data review for corrective action**	
	Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when	yes

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

	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