

PREA Facility Audit Report: Final

Name of Facility: Brighter Path Tuscaloosa S.O.A.R.

Facility Type: Juvenile

Date Interim Report Submitted: 05/12/2026

Date Final Report Submitted: 08/18/2026

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: 08/18/2026

AUDITOR INFORMATION

Auditor name: Davis, Latera

Email: laterad@yahoo.com

Start Date of On-Site Audit: 03/12/2026

End Date of On-Site Audit: 03/13/2026

FACILITY INFORMATION

Facility name: Brighter Path Tuscaloosa S.O.A.R.

Facility physical address: 6001 12th Avenue East, Tuscaloosa, Alabama - 35405

Facility mailing address:

Primary Contact

Name:	Jamarr Lewis
Email Address:	jamarr.lewis@rop.com
Telephone Number:	2053432875

Superintendent/Director/Administrator	
Name:	Jamarr Lewis
Email Address:	jamarr.lewis@rop.com
Telephone Number:	2053432875

Facility PREA Compliance Manager	
Name:	Jamarr Lewis
Email Address:	Jamarr.Lewis@bptuscaloosa.com
Telephone Number:	659-346-6361

Facility Health Service Administrator On-Site	
Name:	Daniel Perkins
Email Address:	dperkins@mcmh.us
Telephone Number:	8503333675

Facility Characteristics	
Designed facility capacity:	16
Current population of facility:	16
Average daily population for the past 12 months:	15
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Women/girls

Age range of population:	12 to 18
Facility security levels/resident custody levels:	medium risk
Number of staff currently employed at the facility who may have contact with residents:	27
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	10
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION

Name of agency:	Brighter Path Alabama, LLC.
Governing authority or parent agency (if applicable):	
Physical Address:	1907 U.S. 301, Suite C150, Tampa, Florida - 33619
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:

Name:	
Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information

Name:	Bette Moore	Email Address:	Bette.Moore@brighterpathal.com
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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:

0

Number of standards met:

43

Number of standards not met:

0

POST-AUDIT REPORTING INFORMATION

Please note: Question numbers may not appear sequentially as some questions are omitted from the report and used solely for internal reporting purposes.

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2026-03-12
2. End date of the onsite portion of the audit:	2026-03-13

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:	JDI DYS Advocates

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	16
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

23. Enter the total number of inmates/residents/detainees in the facility as of the first day of onsite portion of the audit:	14
25. 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
26. 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
27. 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
28. 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
29. 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
30. 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

31. 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
32. 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:	1
33. 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:	5
34. 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
35. 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):	As of the first day of the onsite audit, the facility's inmate/resident population remained stable with no significant shifts in demographic characteristics. All required population categories were tracked accurately, and no issues were identified regarding the facility's ability to classify or identify specific groups. The facility reported no untracked populations or gaps in demographic data that would impact assessment, screening, or service provision.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
36. 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:	27

37. 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:	5
38. 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:	2
39. 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:	The facility had a diversity in terms of age, gender, ethnicity and background of staff, volunteers and contractors. While the facility had a high turnover rate, there was a range of experience and expertise among staff. The facility employed a versatile staff force that had notable qualification and specialized skills to contribute to the overall facility operations.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

40. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	10
41. 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

42. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	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 identify any targeted populations.
43. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	☒ Yes ☐ No
44. 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):	Random inmate/resident selections for interviews were conducted without barriers, and the sample reflected a representative cross-section of the facility population. The auditor oversampled certain groups to ensure adequate representation of younger residents, and individuals with limited program participation. No significant obstacles were encountered in completing interviews, and all requested individuals were made available, allowing for a comprehensive and balanced assessment.
Targeted Inmate/Resident/Detainee Interviews	
45. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	7
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".	

47. 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
a. 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.
b. 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).	Upon review of files and information reported by the facility, there were no targeted residents who met the criteria.
48. 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
a. 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.

b. 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).	Upon review of files and information reported by the facility, there were no targeted residents who met the criteria.
49. 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
a. 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.
b. 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).	Upon review of files and information reported by the facility, there were no targeted residents who met the criteria.
50. 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
a. 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.

b. 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).	Upon review of files and information reported by the facility, there were no targeted residents who met the criteria.
51. 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
a. 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.
b. 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).	Upon review of files and information reported by the facility, there were no targeted residents who met the criteria.
52. 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
a. 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.

b. 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).	Upon review of files and information reported by the facility, there were no targeted residents who met the criteria.
53. 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
a. 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.
b. 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).	Upon review of files and information reported by the facility, there were no targeted residents who met the criteria.
54. 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:	2
55. 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:	5

56. 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
a. 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.
b. 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).	Upon review of files and information reported by the facility, there were no targeted residents who met the criteria.

57. 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	
58. Enter the total number of RANDOM STAFF who were interviewed:	7

59. 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
60. Were you able to conduct the minimum number of RANDOM STAFF interviews?	☐ Yes ☒ No
a. 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
61. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	All staff who were employed and at work were interviewed.

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.

62. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):

15

63. Were you able to interview the Agency Head?

☒ Yes

☐ No

64. Were you able to interview the Warden/Facility Director/Superintendent or their designee?

☒ Yes

☐ No

65. Were you able to interview the PREA Coordinator?

☒ Yes

☐ No

66. 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)

67. 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
68. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?	☒ Yes ☐ No
a. Enter the total number of VOLUNTEERS who were interviewed:	1
b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Education/programming ☐ Medical/dental ☒ Mental health/counseling ☐ Religious ☐ Other
69. Did you interview CONTRACTORS who may have contact with inmates/residents/detainees in this facility?	☒ Yes ☐ No
a. Enter the total number of CONTRACTORS who were interviewed:	1
b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☐ Education/programming ☒ Medical/dental ☐ Food service ☐ Maintenance/construction ☐ Other

70. Provide any additional comments regarding selecting or interviewing specialized staff.	Interviews with random staff were conducted across various shifts, housing units, and job classifications to ensure broad representation. Staff were selected from rosters using a random sampling method, with an emphasis on including a mix of security staff, medical personnel, education and program staff, and support services.
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.	
71. Did you have access to all areas of the facility?	☒ Yes ☐ No
Was the site review an active, inquiring process that included the following:	
72. 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
73. 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

74. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	☒ Yes ☐ No
75. Informal conversations with staff during the site review (encouraged, not required)?	☒ Yes ☐ No
76. 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.

77. 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

78. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).

During the audit process, I took several steps 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.

79. 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	2	1	2	1
Total	2	1	2	1

80. 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	0	0	0	0
Staff-on-inmate sexual harassment	1	0	1	0
Total	1	0	1	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.

81. 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

82. 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.

83. 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

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

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	1	0
Staff-on-inmate sexual harassment	0	0	1	0
Total	0	0	2	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

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

0

a. Explain why you were unable to review any sexual abuse investigation files:

There were no reported sexual abuse investigations.

86. 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	
87. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
88. 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)
89. 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	
90. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
91. 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)

92. 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	
93. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	3
94. 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	
95. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	2
96. 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)
97. 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

98. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:

1

99. 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)

100. 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)

101. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.

All allegations were reviewed.

SUPPORT STAFF INFORMATION**DOJ-certified PREA Auditors Support Staff**

102. 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

103. 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

a. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:

1

AUDITING ARRANGEMENTS AND COMPENSATION

108. 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: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: - Documents: (Policies, directives, forms, files, records, etc.) - Pre-Audit Questionnaire (PAQ) - Policy: PREA (Prison Rape Elimination Act) - Rite of Passage Policy - Organizational Chart (Agency) - Interviews: - PREA Coordinator - 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 PREA (Prison Rape Elimination Act), "The facility has a zero-tolerance policy related to sexual abuse or sexual harassment of a resident and will cooperate in the investigation and prosecution of anyone involved in a sexual abuse and/or sexual harassment of a resident. The facility staff will implement and understand the approach to take when preventing, detecting, and responding to sexual abuse and sexual harassment. The primary responsibility of all facility employees is resident safety. This policy shall be followed in conjunction with all Federal and State mandatory reporting requirements." (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.
- During the course of the audit phase the facility was sold to Right of Passage. The Right of Passage policy will also be included from mid-February 2026 moving forward.

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, Texas Regional Compliance Director. According to the agency organizational chart, the agency PREA coordinator reports to the Executive Director of Operations. 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 PREA Coordinator reports having sufficient time and capacity to effectively carry out all assigned PREA-related responsibilities. Each site has a designated PREA Compliance Manager, and the Coordinator maintains regular oversight and engagement through monthly compliance calls that include training and discussion of PREA-related matters. When deficiencies are identified, the Coordinator collaborates with site leadership to develop corrective action plans, provide targeted training, and monitor progress until compliance is achieved.

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 Program Director 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 person to whom the PREA Compliance Manager reports: Regional Director of Operations.

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

Interviews:

PREA Compliance Manager: The PREA Compliance Manager reports generally having sufficient time to manage PREA responsibilities, with acknowledgment that additional staffing support is being pursued to enhance capacity. The Manager coordinates compliance through ongoing audits, policy updates, scheduling, and ensuring both staff and residents are educated on PREA standards. When compliance issues arise, the Manager reviews the deficiency, implements corrective actions, and adjusts practices to ensure alignment with PREA 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. 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.
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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) b. ROP Contract 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 (1) 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 (1) 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.
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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: PREA (Prison Rape Elimination Act) Supervision and Monitoring-Staffing Plan c. SAFE Environments Policy

- d. Unannounced Rounds (12 months)
- e. Staffing Plan (2025/20226)
- 2. Interviews:
 - a. Superintendent (Facility Director)
 - b. PREA Coordinator
 - c. PREA Compliance Manager
 - d. Intermediate or higher-level staff (1)
- 3. Site Review
- 4. Corrective Action
 - a. Staffing List
 - b. Recruitment Efforts

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: 15. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents on which the staffing plan was predicated: 15.

It should be noted that the facility provided a staffing schedule.

Documented annual staffing plan provides a staffing plan that provides for adequate levels of staffing (2025/2026 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 one building: The site houses, programs, and provides educational services for each dormitory separately. Each dorm can house eight residents.

Day Shift:

During the day, the auditor observed limited staffing levels. While there was at least one staff with the residents at times the education, medical and mental health staff had to provide direct care and relieve staff. Several staff called out of work on both days of the audit. 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 seven residents in the other dorm.

Due to staffing, education services were provided on the unit.

Evening Shift:

Evening shift had three staff; one handling the control room and one per unit.

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 with 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.

The facility is structured as a hard built facility with reinforced concrete, steel, and masonry; integrated security systems; designed for controlled movement of residents. This includes secure housing units, control rooms. Sally ports, and secure corridors.

Audit Observations and Resident Feedback:

Staffing concerns were identified during the onsite audit. The auditor engaged in informal conversations with on-site staff and residents; who also expressed concern with staff levels.

While the facility had limited staff during the audit the overall staffing plan appears to support adequate supervision. Staff were observed conducting routine rounds and maintaining active engagement with residents. Cameras are strategically placed throughout the facility to enhance monitoring however camera placement does not compromise resident privacy in bathrooms or shower areas. Any identified blind spots are minimal and mitigated through staff movement and direct supervision practices.

Interviews:

Director/PREA Compliance Manager: When assessing adequate staffing levels and the need for video monitoring we maintain a 8:1 ratio at all times. Cameras are present in most areas, with the exception of bathroom and bedrooms. In those areas, procedures have been established to ensure safety. The following areas are assessed:

- o Generally accepted detention practices: Have not had any.

- o Judicial Findings: Have not had any.
- o Inadequacy from federal investigations: Have not had any.
- o Inadequacy from internal or external oversight bodies: Have not had any.
- o All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); Any area not under video monitoring, only one resident is allowed to be in the bathroom unless a staff member is present to supervisor. Staff are trained to always be under video monitoring if alone with the client.
- o Composition of resident population: by contract, the group home is under a no object/reject clause, meaning all resident deemed appropriate by DYS must be accepted. However, communication is maintained between program staff and DYS representatives whenever a client demonstrates concerning behavior. All residents are given a vulnerability assessment upon admission to determine potential vulnerabilities and assist in establishing staffing levels.
- o The number and placement of supervisory staff: there are never more than eight residents to one staff member. Staff members are trained to position themselves where they can monitor all residents under their supervision. Staffing levels are typically increased during the day when residents are most active.
- o Institution programs: direct care staff are present to ensure good supervision during school, creation time, and optional programming, such as church service.
- o Any applicable state or local laws, regulations, or standards: all are followed
- o The prevalence of substantiated and unsubstantiated incidents of sexual abuse: in the event of a substantiated sexual abuse incident, staffing levels would be increased.

The facility maintains a staffing plan with adequate staffing levels supported by shift checks, movement logs, and regular briefings. Video monitoring is utilized, and the staffing plan is formally documented (e.g., binders/shift reports). Staffing decisions are informed by incident trends, staffing reports, and facility operations. There are no findings of inadequacy from judicial, federal, or oversight bodies. The facility reports no blind spots and considers resident population demographics in planning. Compliance is monitored through checklists, video surveillance, and wand/security systems.

Corrective Actions:

I. Finding:

Staffing levels were limited, impacting consistent supervision and monitoring.

Corrective Action Required

Immediate Mitigation Strategies

The facility shall implement interim measures to ensure adequate supervision despite staffing shortages. This includes prioritizing staff coverage in high-risk areas, adjusting shift assignments to maximize supervision, and increasing supervisory presence through documented rounds. All efforts must reflect a proactive approach to maintaining resident safety.

Documentation and Tracking

The facility shall maintain detailed daily staffing rosters identifying assigned versus filled posts, use of overtime, and any deviations from the staffing plan. All instances of staffing shortages must include documented mitigation efforts. This documentation will be used to demonstrate consistent monitoring and response to staffing challenges.

Auditor Monitoring

The auditor will monitor staffing practices and documentation for a minimum of three (3) months from the onsite audit date to assess sustained compliance.

The facility provided documentation of enhanced staffing and agency efforts to ongoing recruit. Corrective Action measures were met and the facility is compliant with the provisions of the standard.

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 1:6 through the waking hours and 1:8 during sleeping hours.

Interviews:

Director – Instances of non-compliance may occur during program changes; these are documented through internal communication (e.g., emails/texts), though detailed explanations may not always be included.

Corrective Actions:

See 115.313 (a).

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 1:6 during residents' waking hours and 1:8 during residents' sleeping hours. As reported, the facility has not deviated from the staff ratios of 1:8 during waking hours and 1:16 during resident sleeping hours. 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 follows required staffing ratios (e.g., 1:6 daytime, 1:10 nighttime) and utilizes additional staff support or hiring to maintain compliance when needed.

Corrective Actions:

See standard 115.313 (a).

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 (2025/2026). The staffing plan addresses all of the above-mentioned areas.

Interviews:

PREA Coordinator – The interviewed PREA Coordinator reported that when deficiencies are identified, the coordinator collaborates with site leadership to develop corrective action plans, provide targeted training, and monitor progress until compliance is achieved.

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.

While the facility did not previously have a designated policy. They have recently been acquired by a new agency (Rite of Passage). Rite of Passage has the below policy:

Policy: The SAFE Environments Policy states that “Unannounced rounds will be conducted by a Shift Supervisor (or designee) at least once per shift. (b) Site Vulnerability Assessments using the “Site Visit Reporting Form” will be conducted by a Shift Supervisor (or designee) at least once per quarter. (c) All rounds shall be random and unannounced. (d) Documentation of these rounds will be maintained in a log in the Shift Supervisor or designee’s office. (e) Documentation/ findings of these rounds and the “Site Visit Reporting Forms” will be sent quarterly to the RIIP.” (p. 7).

Additionally, the Rite of Passage has policy supporting the above (p. 9).

	Supervision Monitoring Logs: The supervision monitoring logs provided a 12-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 unannounced rounds are conducted to ensure that residents are on schedule and doing what they are supposed to do. The rounds are documented using the supervision logs. Some of the ways used to ensure staff are not alerting each other when rounds are conducted is to just show up, appear like they are there to do other work and observe on cameras. monitor radio conversations. When conducting rounds, walking through the entire facility to see where the staff and residents are located, check on any safety issues or concerns and make sure that everyone is where they are supposed to be. Additionally, cameras are reviewed and 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. Overall Findings: The auditor utilizes a triangulation approach by connecting PREA facility documentation, agency policies, onsite observations, site review of the facility, facility practices, interviews with staff and residents, local and national advocates, and the PREA Audit: Pre-Audit Questionnaire to make determinations. Based on this analysis, compliance with this standard will be determined once identified staffing issues are resolved and the facility demonstrates sustained adequate supervision and monitoring practices. Corrective Action measures were met and the facility is compliant with all provisions of the standard.
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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: PREA (Prison Rape Elimination Act)/Searches, Contraband, Cross-Gender

Viewing

- c. SAFE Environments Policy
- d. Searches Training (see 115.331)
- 2. Interviews:
 - a. Random sample of staff (7)
 - b. Random sample of residents (10)
- 3. Site Review

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. 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 PREA (Prison Rape Elimination Act), states that “A resident may only be searched with significant cause and with the permission by upper-level management, this will only be a pat down search. Residents will only be searched in a private area with two members of the same sex employee. Cross-gender strip, visual body cavity, and pat-down searches are prohibited no exigent circumstances. Residents will never be asked to remove under garments” (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 9).

Staff receive training related to searches during initial hire (see 115.331).

Site Review:

PREA Site Review Summary: Search Practices Compliance Search Observations:

During the site review, the auditor did not observe any searches being conducted. While this limited the opportunity for direct observation of search procedures, the auditor relied on staff interviews and resident feedback to assess compliance with PREA standards. Additionally, staff demonstrated the search process.

Staff Practices:

Through informal conversations and staff interviews, it was consistently reported that cross-gender strip and pat-down searches are strictly prohibited. Staff clearly articulated their understanding of the policy and affirmed that male staff do not conduct pat-down searches on residents. Searches conducted during the intake process are carried out by staff of the same gender as the resident, in alignment with agency policy and PREA requirements. Staff clearly articulated and demonstrated the search procedure, showing how they start from top of the body of resident and search down to feet in a systematic manner. -

Resident Feedback:

Residents interviewed during the site review consistently reported that they have never been subjected to a pat-down search by male staff. They also stated that no staff member has ever conducted a strip search on them. This feedback aligns with staff statements and supports the conclusion that the facility is adhering to PREA search standards.

Overall residents are afforded privacy when using restroom and shower facilities. Privacy barriers including curtains or partitions were observed and functioning appropriately. Staff reported adherence across gender announcement protocols during interview staff demonstrated knowledge of the requirements to announce their presence when entering housing units of the opposite gender.

Interviews

Non-medical staff involved in cross gender strip or visual searches – The interviewed staff reported that they do not conduct cross gender strip searches or visual body searches. Searches are typically done at intake or upon return from visits. Emergency searches could occur.

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 did not involve exigent circumstance(s): 0.

Policy: The PREA (Prison Rape Elimination Act) states that “A resident may only be searched with significant cause and with the permission by upper-level management, this will only be a pat down search. Residents will only be searched in a private area with two members of the same sex employee. Cross-gender strip, visual body cavity, and pat-down searches are prohibited no exigent circumstances. Residents will never be asked to remove under garments” (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 9).

Interviews:

Random Sample of Staff: The interviewed staff reported all staff are restricted from conducting cross gender pat down searches.

Random Sample of Residents: All of the interviewed random sample of residents reported that opposite gender staff have never performed a pat down search of their bodies.

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 PREA (Prison Rape Elimination Act) states that “A resident may only be searched with significant cause and with the permission by upper-level management, this will only be a pat down search. Residents will only be searched in a private area with two members of the same sex employee. Cross-gender strip, visual body cavity, and pat-down searches are prohibited no exigent circumstances. Residents will never be asked to remove under garments” (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 9).

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 PREA (Prison Rape Elimination Act) states that "At all times, residents are able to shower, perform bodily functions and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia area. Except in emergency circumstances or when such viewing is incidental to routine room checks. If these situations were to occur, the viewing will be clearly documented in an incident report kept in the resident's file" (p. 1). Additionally, it states that "Staff of the opposite gender must announce their presence when entering an area where residents are likely to be showering, performing bodily functions or changing clothing" (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 9).

PREA Site Review Summary: Cross-Gender Viewing and Resident Privacy

Observation of Areas Where Residents May Be Undressed:

The auditor conducted a thorough inspection of all areas where residents may be in a state of undress, including while showering, using the toilet, or changing clothes. These activities are limited to the housing unit's bathroom, which includes two individual shower stalls, partial wall toilets.

Each shower stall is equipped with a PREA shower curtain. However the residents reported that the facility just put up the curtains. The residents stated that they would shower one at a time and there was a time were residents would be out of the cell and could see them in the shower. Staff reported that they had a history of residents with self harm behaviors and so they did not have shower curtains and

same gender staff would be positioned near the bathroom. It was further reported that DYS recently recommended that they put up the shower curtains.

Cross-Gender Observation and Privacy:

The auditor assessed potential cross-gender viewing risks from multiple angles, including staff positioning, mirror placement, and camera surveillance. The facility's physical layout prevents non-medical staff of the opposite gender from viewing residents in a state of undress. There are no mirrors positioned in a way that would compromise resident privacy—mirrors are located only above the sink areas and do not provide a line of sight into showers or toilets. Additionally, cross gender staff are not on housing unit during shower time.

Additionally, a review of the electronic surveillance system confirmed that restroom and shower areas are not monitored, and management staff do not have camera access to locations where residents might be unclothed. The camera system is monitored from the control room.

Staff and Resident Feedback:

Direct care staff confirmed that residents are only permitted to shower in the designated bathroom. Only one residents is allowed in the bathroom at a time. Staff emphasized that residents must be fully clothed at all times outside of the bathroom and that removing shirts or walking around partially dressed is not permitted.

Residents reported that prior to the audit they were uncomfortable with other residents and staff being able to see them in the shower.

Opposite-Gender Announcements:

During the site review, the auditor noted that opposite-gender staff did make an announcement when entering the housing area or restroom. Residents must request permission to enter the restroom, further supporting the privacy protocol.

In informal interviews, staff stated that opposite-gender announcements are a routine practice. Residents confirmed this, noting that such announcements are typically made either by the entering staff member or another male staff member. Residents also stated that opposite-gender staff rarely, if ever, enter the restroom area when it is in use by residents.

Staff reported adherence to cross gender announcement protocols. During interviews staff demonstrated knowledge of the requirement to announce their presence when entering housing units of the opposite gender. No concerns related to cross gender viewing or searches were identified during the site review.

Interviews:

Random Sample of Staff: The interviewed staff were consistent in their response that staff announce their presence when entering a housing unit that houses resident of the opposite gender. After probing interviewed staff, each consistently gave similar examples of what is stated when entering the housing unit of the opposite gender. All of the staff reported that residents are able to dress, shower,

	and use the toilet without being viewed by staff of the opposite gender. Random Sample of Residents- The interviewed random sample of residents stated that staff of the opposite gender do announce their presence when entering the housing area or where they shower, change clothes, or preform bodily functions. All residents interviewed reported that staff do not come in the area when they shower or change clothes. All of the interviewed residents stated that they are not naked in full view of any staff. However it should be noted that the residents complained that the shower curtains were just put up and other residents could see them in the shower. It should be noted that the auditor probed the shower curtain placement with the Director. It was reported that DYS recently recommended that they place the shower curtains up as a number of residents complained about other residents being able to see them in the shower. It was further reported that staff did not feel it was necessary to have the curtains due to the number of residents who had suicidal ideations. 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 (e.) This provision is no longer applicable. 115.315 (f). This provision is no longer applicable. 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.
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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 PREA (Prison Rape Elimination Act)
 - b. Rite of Passage: Safe Environment Standards
 - c. PREA Brochure (English/Spanish)
 - d. Contract for Interpreter Services (Blind and Deaf Agreement)
 - e. Tuscaloosa City Board of Education
2. Interviews:
 - a. Random sample of staff (7)
 - b. Residents with Disabilities or Limited English Speaking (0)
3. Site-Review
4. Corrective Action:
 - a. AIDB Interpreter Contract

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 PREA (Prison Rape Elimination Act) states that: The facility will take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of DYS'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, facilities 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 (p. 1)

Additionally, SAFE Environments Policy has language to support the above (p. 10).

PREA Brochure: The agency also provided written materials in formats or through methods that ensure effective communication with residents/residents, in English and Spanish.

Tuscaloosa City Schools provides interpretation or services for those with various disabilities.

Alabama Institute for Deaf and Blind provides interpretation services.

PREA Site Review Summary: Interpretation and Language Access Services Access to Interpretation Services:

Although the facility did not have any limited English proficient (LEP) residents at the time of the audit, the auditor was able to successfully test the availability and functionality of the facility's contracted on-demand interpretation services. To do so, the auditor-initiated contact with the contracted language line service and engaged facility staff in a walkthrough of the access process.

Direct care staff are not fully aware on how to utilize services as they said they have not done so in the past however reported that they would contact the director to determine how to utilize language line services. The medical staff had a clear understanding of how to access services as they reported the use of services for a parent who was deaf or hard of hearing to communicate with and to communicate with the child while at the placement.

System Access and Limitations:

Residents are not required to self-identify in order to access interpretation services. However, use of the contracted interpretation line requires entry of a facility-specific PIN, which limits direct resident access. Since residents do not have unsupervised or on-demand access to telephones, interpreter services must be initiated and facilitated by staff. Interpreter services are available 24 hours a day, 7 days a week,

ensuring continuous access when needed.

Implementation and Location of Services:

According to the facility's Director, any use of interpretation services would be conducted privately and confidentially with the door closed to preserve confidentiality and dignity. Staff emphasized that interpreter services would be coordinated between mental health staff and the Director when needed. It was also reported that staff would have to speak to leadership to assist youth with accessing services.

Interviews:

Agency Head: The agency has established procedures to ensure equal access for residents with disabilities or limited English proficiency. This includes use of interpretation services, contracts with language providers, and hiring staff reflective of the population's demographics to assist with communication needs.

Corrective Actions:

Written Material: The facility did not have readily access available interpretation services to the residents or information that was for disabled youth. However during the site review the author did observe prior posting in Spanish and English.

Ø Corrective Action Implemented: the facility obtained an executed interpreter (AIDB) contract.

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 PREA (Prison Rape Elimination Act) states that "The facility will provide juvenile orientation in formats accessible to all juveniles, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to juveniles who have limited reading skills (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 10).

PREA Brochure: The agency also provided written materials in formats or through methods that ensure effective communication with residents/residents, in English and Spanish.

In the event interpreter services are needed, the program will utilize services attained by Alabama DYS (Visual Language Professionals LLC).

Interviews:

Resident with Disabilities or Limited English Speaking: There were no residents disabled or Limited English speaking.

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 PREA (Prison Rape Elimination Act) states that "The facility will 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-responder duties, or the investigation of the resident's allegations" (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 10).

	Interviews: Random Sample of Staff: The interviewed random sample of staff reported that they do not allow the use of resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. Several staff reported that they would get an interpreter if one was needed. Staff reported they do not have any residents that would need use of a resident interpreter, resident reader, or any type of resident assistant nor have they had a resident there that would need an interpreter. Resident with Disabilities or Limited English Speaking: There were no residents identified who were disabled or Limited English speaking. 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 corrective action was satisfied and based on analysis, the facility is compliant with all provisions in this standard.
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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 PREA (Prison Rape Elimination Act)/Employee Background Checks, Hiring and Promotion c. Rite of Passage: Safe Environment Standards d. PREA Employment Questionnaire (13)

- e. Background Checks (13)
- f. CANS (26) Child Abuse Check
- g. Five Year Checks (n/a facility has been open less than three years)
- h. Reference Check (26)
- i. Contractor Background Check (1)
- 2. Interviews:
 - a. Administrative (Human Resources) Staff

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, 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.

Policy: The PREA (Prison Rape Elimination Act) states that:

The facility 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 (as defined in 42 U.S.C. 1997); The facility will ask all applicants and employees or contractors, who may have contact with residents, directly in interviews for hiring or promotions and in any interviews or written self-evaluations.

(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 (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 11).

New Hire Criminal Background Checks (13)

Child Abuse Check (26)

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 (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 PREA (Prison Rape Elimination Act) states that "The facility 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 residents. (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 11).

Pre-Employment Questionnaire (13): prior to hiring, the agency performs a criminal background records check and makes efforts to contact prior institutional employers to obtain information on any substantiated allegations of sexual abuse or resignations during pending investigations. The hiring process includes screening for prior sexual abuse convictions, pending charges, or behaviors that indicate a risk of

sexual misconduct. Any applicant found to have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution is disqualified from employment.

All background checks are documented and retained according to agency policy. The facility ensures that no employee, contractor, or volunteer with disqualifying behavior is hired or retained. This practice reflects the facility's commitment to maintaining a safe, secure, and PREA-compliant environment for all residents.

Child Abuse Check (26).

Interviews:

Administrative (Human Resources) – The facility confirms that prior incidents of sexual harassment or misconduct are considered during hiring and promotion decisions. PREA-related documentation and pre-employment questionnaires are utilized, and institutional reference checks are conducted.

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 (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: 11.

Policy: The PREA (Prison Rape Elimination Act) states that:

The facility requires that before hire of any new employees who may have contact with residents, it (a) conducts criminal background record checks, (b) consults any

child abuse registry maintained by the State or locality in which the employee would work; and (c) consistent with Federal, State, and local law, makes 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 (pp. 1-2).

Additionally, SAFE Environments Policy has language to support the above (p. 11).

Personnel Files New Hire Background Checks (13): Prior to hiring, the agency performs a criminal background records check and makes efforts to contact prior institutional employers to obtain information on any substantiated allegations of sexual abuse or resignations during pending investigations. The hiring process includes screening for prior sexual abuse convictions, pending charges, or behaviors that indicate a risk of sexual misconduct. Any applicant found to have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution is disqualified from employment.

All background checks are documented and retained according to agency policy. The facility ensures that no employee, contractor, or volunteer with disqualifying behavior is hired or retained. This practice reflects the facility's commitment to maintaining a safe, secure, and PREA-compliant environment for all residents.

Interviews:

Administrative (Human Resources)- The facility reports that criminal background checks are conducted for all newly hired employees and for employees being considered for promotion who may have contact with residents. This practice also extends to contractors, including contracted medical staff and agency employees. The facility conducts child abuse registry checks prior to hiring employees or contractors. Additional screening measures include reference checks and third-party background checks.

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 (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: 1.

Policy: The PREA (Prison Rape Elimination Act) states that:

The facility requires that a criminal background record check be completed and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents.

Applicants must complete an application statement and driving record form authorizing the facility to perform background checks.

Background check results will be stored in the employee's personnel file. These checks include Below list all facility background check requirements:

1. Criminal History unit background check
2. Sex Offender Registry
3. National Sex Offender Registry
4. State Driver's License Look Up
5. National Motor Vehicle Check Look Up
6. Board of Occupational Licenses
7. Office of Inspector General
8. Data Facts (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 11). It should also be noted that the background check includes the Alabama child abuse registry check.

Background check for one contracted staff was reviewed.

Interviews

Administrative (Human Resources) - The facility reports that criminal background checks are conducted for all newly hired employees and for employees being considered for promotion who may have contact with residents. This practice also extends to contractors, including contracted medical staff and agency employees.

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 PREA (Prison Rape Elimination Act) states that “The facility requires that criminal background record checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees” (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 12).

Five Year Background Check: The facility has not been operation for five years; therefore, does not have any staff employed to meet the five-year threshold.

Interviews:

Administrative (Human Resources) - The facility utilizes GCIC and National Crime Information Center (NCIC) checks, along with Department of Administrative Services (DOAS) processes. Background checks are conducted at least every five years. The facility also tracks allegations and criminal history updates.

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 (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.

Pre-employment Reference Checks (26): Pre-employment reference checks are conducted assessing prior work institutional misconduct.

Interviews

Administrative (Human Resources) – Applicants and employees are required to disclose prior misconduct through pre-employment questionnaires and during hiring and evaluation processes. The facility imposes an ongoing affirmative duty for employees to disclose any prior misconduct. This requirement is embedded in the application process and reinforced through periodic/random checks.

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 (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 PREA (Prison Rape Elimination Act) states that "Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination" (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 12).

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. Based on analysis, the facility is compliant with all provisions in this standard.
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115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Pre-Audit Questionnaire (PAQ)
 - a. Policy: The PREA (Prison Rape Elimination Act)
 - b. Rite of Passage: Safe Environment Standards
 - c. PREA Brochure (English/Spanish)
 - d. Contract for Interpreter Services (Blind and Deaf Agreement)
 - e. Tuscaloosa City Board of Education
2. Interviews:
 - a. Random sample of staff (7)
 - b. Residents with Disabilities or Limited English Speaking (0)
3. Site-Review

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 PREA (Prison Rape Elimination Act) states that: The facility will take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of DYS'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, facilities 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 (p. 1)

Additionally, SAFE Environments Policy has language to support the above (p. 10).

PREA Brochure: The agency also provided written materials in formats or through methods that ensure effective communication with residents/residents, in English and Spanish.

Tuscaloosa City Schools provides interpretation or services for those with various disabilities.

Alabama Institute for Deaf and Blind provides interpretation services.

PREA Site Review Summary: Interpretation and Language Access Services Access to Interpretation Services:

Although the facility did not have any limited English proficient (LEP) residents at the time of the audit, the auditor was able to successfully test the availability and functionality of the facility's contracted on-demand interpretation services. To do so, the auditor-initiated contact with the contracted language line service and engaged facility staff in a walkthrough of the access process.

Direct care staff are not fully aware on how to utilize services as they said they have not done so in the past however reported that they would contact the director to determine how to utilize language line services. The medical staff had a clear understanding of how to access services as they reported the use of services for a parent who was deaf or hard of hearing to communicate with and to communicate with the child while at the placement.

System Access and Limitations:

Residents are not required to self-identify in order to access interpretation services. However, use of the contracted interpretation line requires entry of a facility-specific PIN, which limits direct resident access. Since residents do not have unsupervised or on-demand access to telephones, interpreter services must be initiated and facilitated by staff. Interpreter services are available 24 hours a day, 7 days a week, ensuring continuous access when needed.

Implementation and Location of Services:

According to the facility's Director, any use of interpretation services would be conducted privately and confidentially with the door closed to preserve confidentiality and dignity. Staff emphasized that interpreter services would be coordinated between mental health staff and the Director when needed. It was also reported that staff would have to speak to leadership to assist youth with accessing services.

Interviews:

Agency Head: The agency has established procedures to ensure equal access for residents with disabilities or limited English proficiency. This includes use of interpretation services, contracts with language providers, and hiring staff reflective of the population's demographics to assist with communication needs.

Corrective Actions:

I. Finding: During the onsite review, it was identified that the facility did not have readily accessible information regarding interpretation services for residents or materials tailored for youth with disabilities. While postings in English and Spanish were observed, they did not fully address accessibility requirements.

Corrective Action: As part of corrective action, the facility developed a comprehensive informational flyer outlining available interpretation services and accommodations for residents with disabilities. The flyer includes clear guidance on how residents can access language assistance and support services. The material was designed to be easily understood and accessible to a broad population.

The facility has posted the updated flyer throughout the facility in strategic locations to ensure visibility and access for all residents. These actions demonstrate corrective measures taken to improve accessibility and align with PREA requirements regarding resident access to information.

II. Finding:

The facility was unable to provide current documentation verifying a renewed or active contract for disability services to ensure effective communication and accommodations for residents with disabilities.

Corrective Action Required:

The facility shall obtain and provide documentation of a renewed or active contract with a qualified provider for disability services. The contract must clearly outline the provision of accommodations, including but not limited to interpretive services, assistance for residents with hearing, vision, or cognitive impairments, and access to PREA-related information in an accessible format.

The facility shall submit a copy of the executed contract to the auditor for review. Documentation must demonstrate that services are current, accessible, and available to residents as required under PREA Standard 115.316.

Compliance Determination:

Compliance will be achieved once the facility provides verification of an active contract and demonstrates that disability services are in place and accessible to residents. The auditor will review submitted documentation to confirm alignment with PREA requirements.

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 PREA (Prison Rape Elimination Act) states that "The facility will provide juvenile orientation in formats accessible to all juveniles, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to juveniles who have limited reading skills (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 10).

PREA Brochure: The agency also provided written materials in formats or through methods that ensure effective communication with residents/residents, in English and Spanish.

Interviews:

Resident with Disabilities or Limited English Speaking: There were no residents disabled or Limited English speaking.

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 PREA (Prison Rape Elimination Act) states that "The facility will 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-responder duties, or the investigation of the resident's allegations" (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 10).

Interviews:

Random Sample of Staff: The interviewed random sample of staff reported that they do not allow the use of resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. Several staff reported that they would get an interpreter if one was needed. Staff reported they do not have any residents that would need use of a resident interpreter, resident reader, or any type of resident assistant nor have they had a resident there that would need an interpreter.

Resident with Disabilities or Limited English Speaking: There were no residents identified who were disabled or Limited English speaking.

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 utilizes a triangulation approach by connecting PREA facility documentation, agency policies, onsite observations, facility practices, interviews with staff and residents, local and national advocates, and the PREA Audit: Pre-Audit Questionnaire to make determinations. Based on this analysis, compliance with this

	standard will be determined upon receipt and review of the updated contract for disability services.
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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 PREA (Prison Rape Elimination Act)/Evidence Protocol and Forensic Medical Examinations c. Rite of Passage/Safe Environment Standards d. LOA: Tuscaloosa SAFE Center e. Email Correspondence Walker County Child Advocacy Center f. Email Correspondence: Walker County Sheriff's Office g. Victim Advocacy and Emotional Support Flyer (115.353) 2. Interviews: a. Random sample of staff (7) b. PREA Coordinator c. PREA Compliance Manager d. Resident who Reported a Sexual Abuse/Harassment (2) e. Advocacy Center 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 not 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 PREA (Prison Rape Elimination Act) states that:

The facility is not responsible for conducting administrative sexual abuse investigations, including resident on resident sexual abuse or staff sexual misconduct were applicable. The facility will not conduct a criminal investigation. Tuscaloosa Police Dept will be responsible for both the Administrative and criminal sexual abuse investigations. The facility will contact the Law Enforcement in the event of abuse allegations.

Tuscaloosa Police Dept will investigate all allegations of sexual abuse and will follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

The facility does not perform forensic examinations. The facility provides access to forensic medical examinations off-site, without financial cost to the resident. Forensic medical examinations will only be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). The facility will document these efforts. When SANEs or SAFEs are not available, a qualified medical practitioner will perform the forensic medical evaluation (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 14).

Multiple attempts were made to meet with the victim advocacy center. The auditor did not receive a response. The auditor verified through the website that the agency provides victim advocacy, emotional support, and forensic services.

Interviews

Random Sample of Staff: The interviewed random sample of staff reported that they were aware of the agency's protocol for obtaining usable physical evidence. Each member of staff had various explanations of the protocols which included they would not allow them to shower, brush teeth, or change clothes; they would treat the room like a crime scene and not allow anyone in the area. Call supervisor and the nursing staff. Keep everyone separated and keep visual site on those involved. When asked who conducts the interviews staff reported several administrative staff such as the Facility Director, law enforcement, and 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 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 PREA (Prison Rape Elimination Act) states that:

The facility is not responsible for conducting administrative sexual abuse investigations, including resident on resident sexual abuse or staff sexual misconduct were applicable. The facility will not conduct a criminal investigation.

Tuscaloosa Police Dept will be responsible for both the Administrative and criminal sexual abuse investigations. The facility will contact the Law Enforcement in the event of abuse allegations.

Tuscaloosa Police Dept will investigate all allegations of sexual abuse and will follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions" (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 14).

The Advocacy Center (Tuscaloosa SAFE Center) is utilized by the agency under the umbrella of the Alabama Network of Advocacy Centers. Email correspondence with the advocacy center confirmed 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.

115.321 (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 Prison Rape Elimination Act states that "The facility does not perform forensic examinations. The facility provides access to forensic medical examinations off-site, without financial cost to the resident. Forensic medical examinations will only be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). The facility will document these efforts. When SANEs or SAFEs are not available, a qualified medical practitioner will perform the forensic medical evaluation" (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 14).

Forensic medical exams are conducted by Tuscaloosa SAFE 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.

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: Rape Crisis Center states that the Child Advocacy Center will accompany a youth during the forensic examination process. Additionally, the letter of intent (115.322) provides an overview of the victim advocacy and emotional support services that the child advocacy center will provide to any referred victim.

Interviews:

PREA Compliance Manager – Advocacy services are available on a continuous (24/7) basis through community partnerships. Advocacy services are governed by contractual agreements, with monitoring to ensure compliance with required standards.

Residents who Reported a Sexual Abuse/Harassment – Two resident did state they reported sexual harassment. The residents reported that they did not or was not allowed to contact anyone. They reported that nothing happened and nobody has spoken to them about the 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.

115.321 (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 PREA (Prison Rape Elimination Act) states that “Upon request of the resident, the facility will allow the victim advocate or qualified community-based organization staff member to accompany the resident through the forensic medical exam process as well as investigatory interviews to provide emotional support, crisis intervention, information and referrals” (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 14).

MOU: Rape Crisis Center states that the Child Advocacy Center will accompany a youth during the forensic examination process. Additionally, the letter of intent (115.322) provides an overview of the victim advocacy and emotional support services that the child advocacy center will provide to any referred victim.

PREA Advocacy Flyer: The PREA Advocacy Flyer provides residents with information on victim advocacy and emotional support. The flyer also contains the contact information of the Tuscaloosa Safe Child Advocacy Center (115.353).

Interviews:

PREA Compliance Manager – Victim advocates are available to provide support, with safeguards in place to ensure they do not influence investigative processes.

Residents who Reported a Sexual Abuse Harassment – Two resident did state they reported sexual harassment. The residents reported that they did not or was not allowed to contact anyone. They reported that nothing happened and nobody has spoken to them about the 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.

115.321 (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 a letter with Tuscaloosa 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 will utilize its mental health staff if necessary to assist with victim advocacy and emotional supportive 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.
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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 PREA (Prison Rape Elimination Act)/Referrals for Internal and External Investigations
- c. Rite of Passage/Safe Environment Standards
- d. Website: Safe Standards - Rite of Passage
- e. Investigations (3)

2. Interviews:

- a. Agency head
- b. Investigative staff (1)

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. 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: 1. In the past 12 months, the number of allegations referred for criminal investigation: 2.

The prior policy did not provide information addressing the standard; however the current agency policy states:

POLICY The program shall ensure that an administrative investigation is completed for all allegations of sexual abuse and sexual harassment. PROCEDURE (a) Allegations of sexual abuse or sexual harassment will be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The determination of whether an allegation involves potentially criminal behavior will be made by the Program Director and Corporate Director of Human Resources. (b)The organization shall publish such policy on its website. (c)All referrals shall be documented. (d) If a criminal investigation is conducted, the program will provide the following: 1.

Incident/ Information Reports 2. Access to program and location of the incident 3. Access to students and / or staff involved 4. Access to all records deemed necessary to complete the investigation (p. 16).

Investigation Reports: The auditor was able to review the three reported investigations in the last 12 months. Administrative and referrals for criminal investigations were reviewed.

Interviews

Agency Head: The agency ensures that all allegations of sexual abuse or sexual harassment are investigated administratively and/or criminally, as appropriate.

Upon receiving an allegation, the agency immediately separates involved individuals, preserves evidence, and contacts law enforcement if the allegation is potentially criminal. Internal investigations include staff and resident interviews, video review, and documentation collection. Investigations are reviewed collaboratively by compliance leadership to ensure thoroughness and adherence to PREA 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.

115.322 (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 to the auditor 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.

The prior policy did not provide information addressing the standard; however, the current agency policy states:

POLICY The program shall ensure that an administrative investigation is completed for all allegations of sexual abuse and sexual harassment. PROCEDURE (a)

Allegations of sexual abuse or sexual harassment will be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The determination of whether an allegation involves potentially criminal behavior will be made by the Program Director and Corporate Director of Human Resources. (b)The organization shall publish such policy on its website. (c)All referrals shall be documented. (d) If a criminal investigation is conducted, the program will provide the following: 1. Incident/ Information Reports 2. Access to program and location of the incident 3. Access to students and / or staff involved 4. Access to all records deemed necessary to complete the investigation (p. 16).

The investigation process of the policy is posted on the website offering public availability. (Safe Standards - Rite of Passage)

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, DYS or 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.

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 investigation process of the policy is posted on the website offering public availability. (Safe Standards - Rite of Passage)

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.
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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 PREA (Prison Rape Elimination Act)/Sexual Abuse/Harassment Training c. Rite of Passage/Safe Environment Standards d. Acknowledgement and Receipt of PREA Training (7) e. New Hire Training (5) f. Training Documents PPT 2. Interviews: a. Random sample of staff (7) 3. Corrective Action a. Additional Training (7) b. New Hire Training c. Training Curriculum 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.

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 PREA (Prison Rape Elimination Act) states that:

A. Professional Specialist/Child Care/ Security Staff. This includes youth services

specialists, counselor I's, youth service aides, childcare workers, shift supervisors, case managers, social workers, psychologists, teachers, medical personnel (contract and DYS), recreation specialists, and security. This specialized training will be offered in pre-service to all new employees, and annually in Mandatory A.

1. Sexual abuse/assault/harassment training shall cover the following areas:

a. Sequel zero-tolerance Policy.311on sexual abuse/assault and harassment.

b. How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;

c. Juvenile's right to be free from sexual abuse and sexual harassment;

d. The right of juveniles and employees to be free from retaliation for reporting sexual abuse and sexual harassment;

e. The dynamics of sexual abuse and sexual harassment in juvenile facilities;

f. The common reactions of juvenile victims of sexual abuse and sexual harassment;

a. 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 juveniles;

b. How to avoid inappropriate relationships with juveniles;

c. How to communicate effectively and professionally with juveniles, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming juveniles; and

d. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities

e. Relevant laws regarding the applicable age of consent. (pp. 2-3).

Additionally, SAFE Environments Policy has language to support the above (pp. 17-18).

· Training Curriculum: The agency utilizes the PREA Employee Training Curriculum, available through Alabama DYS and Rites of Passage.

· Sample of Training Record: New Hire (7); The agency has a process where training is documented for PREA New Hire, Refresher and Mandatory Reporter Training.

Interviews

Random Sample of Staff – The interviewed staff reported that they have been trained on the agencies zero tolerance policy for sexual abuse and sexual

harassment. The staff reported that the training included:

- a. The agency's zero-tolerance policy on sexual abuse and sexual harassment?
- b. How to fulfill your responsibilities regarding sexual abuse and sexual harassment prevention, detection, reporting, and response, in accordance with agency policies and procedures?
- c. Resident's right to be free from sexual abuse and sexual harassment?
- d. Residents' and employees' right to free from retaliation for reporting sexual abuse and sexual harassments?
- e. The dynamics of sexual abuse and sexual harassment in confinement?
- f. The common reactions of sexual abuse and sexual harassment victims?
- g. How to detect and respond to signs of threatened and actual sexual abuse?
- h. How to avoid inappropriate relationship with residents?
- i. How to communicate effectively and professionally with residents, including lesbians, gay, bisexual, transgender, intersex, or gender nonconforming residents?
- j. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?
- k. Relevant laws regarding the applicable age of consent?

The staff consistently reported that they were trained on initial hire and that they received additional training throughout the year. When probed the staff were able to describe things like the common reactions of victims, what to look for, and how to respectfully talk to residents who may be lesbian, gay, bisexual, transgender or gender non-conforming. Additionally, staff reported that they recently went over PREA during a staff meeting.

The facility was recently acquired by a new vendor (Rites of Passage). The new vendor training material was more robust and comprehensive than the prior training provided to staff. Existing staff received training on the new agency training material.

Corrective Actions:

Issue

I. New Hire PREA Training Requirement

The facility shall ensure that all newly hired staff receive PREA training prior to assuming duties or during initial orientation.

Actions Required:

- Implement a procedure requiring PREA training as part of the mandatory onboarding/orientation process.
- Ensure documentation is maintained verifying completion of PREA training by all new hires.

90-Day Monitoring Period

The facility will monitor all newly hired staff for a 90-day period to ensure PREA training is completed as required.

Actions Required:

- Track all new employees hired during the corrective action period.
- Verify PREA training completion for each new hire.
- Maintain a New Hire PREA Training Tracking Log documenting:
 - o Employee name
 - o Hire date
 - o Date PREA training completed
 - o Employee acknowledgment of training

Documentation Required During Corrective Action

The facility shall provide the following documentation to the auditor for the 90-day monitoring period:

1. Updated PREA training curriculum showing all required elements of 115.331(a).
2. Orientation or onboarding procedures demonstrating PREA training requirements for new hires.
3. Training rosters for all PREA employee training conducted during the corrective action period.
4. New Hire PREA Training Tracking Log covering the full 90-day period.
5. Signed employee PREA training acknowledgments or certificates of completion.

Additionally, the auditor requested that all staff receive refresher training. Prior to the interim report being completed, five new hire trainings were provided and seven staff received refresher training. The auditor will continue to monitor.

The above corrective action items were met. The auditor reviewed the PREA training curriculum along with additional training for 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.

115.331 (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. The site is only a female campus.

Policy: The PREA (Prison Rape Elimination Act) states that "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 juveniles to a facility that houses only female juveniles, or vice versa" (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 17-18).

Sample of Training Record: New Hire (7). The agency has a process where training is documented for PREA New Hire, Refresher and Mandatory Reporter Training.

Corrective Actions:

See corrective action in standard 115.331 (a).

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: Bi-Annually.

Sample of Training Record: New Hire (7).

Corrective Actions:

See corrective action in standard 115.331 (a).

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. (7)

Corrective Actions:

See corrective action in standard 115.331 (a).

Overall Findings:

The auditor utilized a triangulation approach to assess the facility's compliance with PREA Standard 115.331. This assessment included a review of facility documentation, agency policies and procedures, onsite observations, facility practices, staff interviews, resident interviews, information obtained from local and national advocacy resources, and the PREA Audit: Pre-Audit Questionnaire.

During the initial audit, the auditor identified a need for the facility to strengthen its monitoring and tracking of staff PREA training to ensure that all employees received the required initial and refresher training in accordance with PREA Standard 115.331.

During the corrective action period, the facility implemented measures to improve the monitoring, tracking, and documentation of staff PREA training. The facility provided the auditor with supporting documentation demonstrating that staff training records are being consistently maintained and monitored to identify and address training requirements.

The auditor reviewed the documentation submitted during the corrective action period and verified that employees received the required PREA training and/or refresher training in accordance with the requirements of Standard 115.331. The documentation further demonstrated that the facility has established a process for ongoing monitoring of staff training to ensure continued compliance with PREA requirements.

	Based on the documentation provided, corrective actions implemented, and the auditor's review and verification, the facility has sufficiently addressed the deficiencies identified during the initial audit. The auditor determines that the corrective action requirements have been successfully completed and the facility is now in compliance with PREA Standard 115.331.
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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 PREA (Prison Rape Elimination Act)/Volunteer and Contractor Training c. Rite of Passage/Safe Environment Standards d. Training Curriculum e. Volunteer/Contractor Training Record (5) 2. Interviews: a. Volunteers or contractors who have contact with residents (2) 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: 7.

Contractor Training Record: The auditor confirmed receipt of training for (5) identified contracted/volunteer staff.

Interviews:

Volunteer(s) or Contractor(s) who have Contact with Residents: Two volunteers were interviewed. The individuals were able to clearly articulate training upon start at the facility along with ongoing training. The volunteers reported being at the facility for a lengthy period of time during various agency changes. Additionally, they were able to describe in person and video-based training, various techniques needed to prevent, report, and respond to 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.

115.332 (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): Volunteers complete the same training as staff as indicated in 115.331.

Contractor Training Record: The auditor confirmed receipt of training for the volunteer and contracted staff (5).

Interviews:

Volunteer(s) or Contractor(s) who have Contact with Residents: Two volunteers were interviewed. The individuals were able to clearly articulate training upon start at the facility along with ongoing training. The volunteers reported being at the facility for a lengthy period of time during various agency changes. Additionally, they were

	able to describe in person and video-based training, various techniques needed to prevent, report, and respond to 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. 115.332 (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. The auditor reviewed documentation of (5) records. 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.
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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. Rite of Passage/Safe Environment Standards
 - c. PREA Pamphlet for Students
 - d. PREA Booklet for Students
 - e. Intake Records PREA Education: Juvenile Confirmation of Receipt of Prison Rape Elimination Act (PREA) (21)
 - f. PREA Posters (English/Spanish)
 - g. Resident Handbook
 - h. Resident Orientation Acknowledgement (21)
2. Interviews:
 - a. staff intake (1)
 - b. Random sample of residents (10)
3. Site Review
4. Corrective Action:
 - a. Handbook Update
 - b. Student Refresher Education (11)

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: 38. It was further reported that the information is provided in an appropriate age fashion.

Policy: The Rite of Passage/Safe Environments Policy states that “PREA (Prison Rape Elimination Act) states that:

POLICY Students shall receive information explaining the program’s zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

PROCEDURE (a) During the intake process, students shall receive ROP Safe Environment Standards “A Student Guide to Rights, Protections, and Reporting of Sexual Abuse” explaining the program’s zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. (b) During the intake process, students shall receive and sign ROP Safe Environment Standards “Student Acknowledgment of Zero Tolerance.” The signed acknowledgment form will be maintained in the Case Management file. (c) Within 10 days of intake during the Orientation Program, the program shall provide comprehensive age-appropriate education to students regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding program policies and procedures for responding to such incidents. (d) Students shall receive education upon transfer to a different program to the extent that the policies and procedures of the student’s new program differ from those of the previous program. (e) The program shall provide student education in formats accessible to all students, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to students who have limited reading skills. (f) The program shall maintain documentation of student participation in these education sessions in the student file. (g) In addition to providing such education, the program shall ensure that key information is continuously and readily available or visible to students through posters, student handbooks, or other written formats (p. 20).

Intake records of residents entering the facility in the last 12 months (21).

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 PREA Booklet to educate the residents on Sexual Abuse and Sexual Harassment. 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. The facility demonstrated resident signature of receipt of PREA education within 72 hours.

PREA Site Review Summary: Intake Process and Interpretation Services

Intake Process Observation

During the site review, the auditor observed the intake area and procedures used to provide residents with PREA education upon admission. Intake is conducted by designated intake supervisors in an administrative building office that includes an

adjoining bathroom and storage space for youth clothing and hygiene supplies. The assessments and PREA education is conducted by medical and mental health services.

Although no new residents were admitted during the audit period, the auditor observed a mock intake conducted by intake staff. The demonstration revealed the following key practices and protocols:

PREA Education Materials: Residents are provided with both the PREA Client Handbook and the Facility Rules Handbook during intake. These materials are written at an appropriate reading level and are accessible to residents with limited English proficiency (LEP), with versions available in both English and Spanish.

Reporting Options: Intake staff clearly explain the multiple avenues available to residents for reporting sexual abuse or harassment. These include:

Writing and submitting a grievance.

Verbally telling any staff member.

Submitting a DYS grievance in the designated grievance box.

Reporting through a parent, attorney, or trusted third party.

Making anonymous reports.

Interpreter Services: Interpreter services are available for residents who are Deaf or have limited English proficiency. Intake staff confirmed they would coordinate with the Facility Director to ensure timely access to these services if needed. Additional interpreter services are offered by the school.

Education and Comprehension Checks: Staff review the PREA and Facility Rules Handbooks with residents, asking follow-up questions and requesting examples to ensure understanding.

Mandatory Reporting and Confidentiality: During intake, residents are informed about the facility's mandatory reporting requirements, including limitations on confidentiality related to disclosures of abuse.

Staff Roles: Intake staff are responsible for providing residents with comprehensive education on the facility's policies regarding sexual abuse and harassment, reporting procedures, and protective measures during their initial orientation.

Resident Feedback

Informal conversations with residents reported that while they knew information about PREA, the facility placed signage up and provided them with three hours of training several days before audit.

Interpretation Services

While there were no LEP residents at the time of the audit, the auditor conducted a live test of the on-demand language line services. Key findings include:

Access and Process: The auditor, in coordination with staff, initiated a call to the language line and was walked through the steps for accessing services without incurring a charge. The process includes entering a secure PIN and selecting from prompts for various languages. The facility has immediate access to nine languages, with additional languages available upon request. Language line is accessible via

DYS.

Resident Access: While residents are not required to self-identify for language services, they cannot independently access the interpretation line due to lack of direct phone access. Interpreter services must be initiated by staff on behalf of residents.

Availability: The language line is available 24/7 and can be accessed at any time with staff assistance.

Service Location and Confidentiality: According to the facility's Clinician, in collaboration with the Director, interpreter calls would be conducted in a private, closed-door setting in the Clinician's Office to maintain confidentiality and comfort for the resident.

Staff Knowledge and Readiness: Intake staff interviewed during formal and informal discussions reported that they are familiar with the protocol and would work with the Director to access interpreter services as needed. Since the facility's opening, there has been no need to use interpreter services, but staff demonstrated preparedness to do so.

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, we go over rights and responsibilities, HIPAA, and PREA information. At the end, the residents will sign acknowledgement of receipt of information. The residents will be asked questions about the information to ensure they understand the information.

Resident Interview Questionnaire: All of the interviewed residents reported that when they first came to the facility, they received information about the facility's rules against sexual abuse and harassment. The information was typically received within a week of entering the facility.

Corrective Actions:

Issue

The audit determined that the facility's resident PREA education materials require enhancement to ensure youth clearly receive and understand information regarding PREA zero tolerance, reporting options, and protection from retaliation. Improvements are needed to strengthen the resident handbook and delivery of PREA education.

Corrective Action Requirements

1. Resident Handbook Enhancement

The facility shall revise the resident handbook to include clear and comprehensive PREA information.

Actions Required:

	Update the handbook to clearly explain: Access to outside reporting resources (to include information on victim advocacy and emotional support) 2. PREA Educational Video for Youth The facility should incorporate a PREA student/youth-focused educational video as part of resident orientation to reinforce PREA education in an accessible and age-appropriate format. Actions Required: Implement the video during intake or orientation. Document resident participation. Corrective Action Completed: Ø Implementation of PREA video Ø Refresher Training with current residents (11) Ø Additional information on victim advocacy and emotional support added to resident handbook 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. Top of Form Bottom of Form 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, 38 residents that were admitted in the facility during the past 12 months, whose 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.
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Resident Education Documentation: The facility tracks resident participation in education sessions by having youth sign for acknowledgement. During the mock intake process, the auditor observed residents signing electronically upon completion of the education. The auditor also reviewed 21 signed Acknowledgement forms.

Sexual abuse and harassment PREA assignment was observed throughout the facility and common areas housing units and intake spaces. Signage includes zero tolerance messaging reporting options and victim advocacy information educational materials appear to be written in language appropriate for the resident population residents' interview were able to articulate their understanding of PREA including how to report.

Intake Process Observation

During the site review, the auditor observed the intake area and procedures used to provide residents with PREA education upon admission. Intake is conducted by designated intake supervisors in an administrative building office that includes an adjoining bathroom and storage space for youth clothing and hygiene supplies.

Although no new residents were admitted during the audit period, the auditor observed a mock intake conducted by intake staff. The demonstration revealed the following key practices and protocols:

PREA Education Materials: Residents are provided with both the PREA Client Handbook and the Facility Rules Handbook during intake. These materials are written at an appropriate reading level and are accessible to residents with limited English proficiency (LEP), with versions available in both English and Spanish.

Reporting Options: Intake staff clearly explain the multiple avenues available to residents for reporting sexual abuse or harassment. These include:

Writing and submitting a grievance.

Verbally telling any staff member.

Submitting a DYS grievance in the designated grievance box.

Reporting through a parent, attorney, or trusted third party.

Making anonymous reports.

Interpreter Services: Interpreter services are available for residents who are Deaf or have limited English proficiency. Intake staff confirmed they would coordinate with the Facility Director to ensure timely access to these services if needed. Additional interpreter services would be offered by the school.

Education and Comprehension Checks: Staff review the PREA and Facility Rules Handbooks with residents, asking follow-up questions and requesting examples to ensure understanding.

Mandatory Reporting and Confidentiality: During intake, residents are informed about the facility's mandatory reporting requirements, including limitations on confidentiality related to disclosures of abuse.

Staff Roles: Intake staff are responsible for providing residents with comprehensive education on the facility's policies regarding sexual abuse and harassment, reporting procedures, and protective measures during their initial orientation.

Resident Feedback

Informal conversations with residents reported that while they knew information about PREA, the facility placed signage up and provided them with three hours of training several days before audit.

Interpretation Services

While there were no LEP residents at the time of the audit, the auditor conducted a live test of the on-demand language line services. Key findings include:

Access and Process: The auditor, in coordination with staff, initiated a call to the language line and was walked through the steps for accessing services without incurring a charge. The process includes entering a secure PIN and selecting from prompts for various languages. The facility has immediate access to nine languages, with additional languages available upon request.

Resident Access: While residents are not required to self-identify for language services, they cannot independently access the interpretation line due to lack of direct phone access. Interpreter services must be initiated by staff on behalf of residents.

Availability: The language line is available 24/7 and can be accessed at any time with staff assistance.

Service Location and Confidentiality: According to the facility's Clinician, in collaboration with the Director, interpreter calls would be conducted in a private, closed-door setting in the Clinician's Office to maintain confidentiality and comfort for the resident.

Staff Knowledge and Readiness: Intake staff interviewed during formal and informal discussions reported that they are familiar with the protocol and would work with the Director to access interpreter services as needed. Since the facility's opening, there has been no need to use interpreter services, but staff demonstrated preparedness to do so.

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 on the policy and procedures, watch a video and verbally discuss before they sign. Usually this will occur on the first day, but it depends on when they arrive. We have not seen any language barriers but there were barriers with access an interpreter.

Resident Interview Questionnaire- All of the interviewed residents reported that when they first came to the facility, they received information about the facility's rules against sexual abuse and harassment. One youth interviewer stated they did receive information within a week but was not completely positive on the

timeframe. From the other youth interviewed, the information was typically received on the first week of entering the facility. It should be noted that the residents did not acknowledge watching a video during intake.

Corrective Actions:

See corrective action in standard 115.333 (a).

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 Rite of Passage/Safe Environments Policy states that "PREA (Prison Rape Elimination Act) states that:

POLICY Students shall receive information explaining the program's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

PROCEDURE (a) During the intake process, students shall receive ROP Safe Environment Standards "A Student Guide to Rights, Protections, and Reporting of Sexual Abuse" explaining the program's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. (b) During the intake process, students shall receive and sign ROP Safe Environment Standards "Student Acknowledgment of Zero Tolerance." The signed acknowledgment form will be maintained in the Case Management file. (c) Within 10 days of intake during the Orientation Program, the program shall provide comprehensive age-appropriate education to students regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding program policies and procedures for responding to such incidents. (d) Students shall receive education upon transfer to a different program to the extent that the policies and procedures of the student's new program differ from those of the previous program. (e) The program shall provide student education in formats accessible to all students, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to students who have limited reading skills. (f) The

program shall maintain documentation of student participation in these education sessions in the student file. (g) In addition to providing such education, the program shall ensure that key information is continuously and readily available or visible to students through posters, student handbooks, or other written formats (p. 20).

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 21 signed Resident Orientation Acknowledgement forms. It was further reported by the staff and residents that the review of resident education 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. The residents are verbally given the information as well as written handouts. Verbal review occurred with the resident to verify that they understand what was provided.

Corrective Actions:

See corrective action in standard 115.333 (a).

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 Rite of Passage/Safe Environments Policy states that "PREA (Prison Rape Elimination Act) states that:

POLICY Students shall receive information explaining the program's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

PROCEDURE (a) During the intake process, students shall receive ROP Safe Environment Standards "A Student Guide to Rights, Protections, and Reporting of

Sexual Abuse” explaining the program’s zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. (b) During the intake process, students shall receive and sign ROP Safe Environment Standards “Student Acknowledgment of Zero Tolerance.” The signed acknowledgment form will be maintained in the Case Management file. (c) Within 10 days of intake during the Orientation Program, the program shall provide comprehensive age-appropriate education to students regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding program policies and procedures for responding to such incidents. (d) Students shall receive education upon transfer to a different program to the extent that the policies and procedures of the student’s new program differ from those of the previous program. (e) The program shall provide student education in formats accessible to all students, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to students who have limited reading skills. (f) The program shall maintain documentation of student participation in these education sessions in the student file. (g) In addition to providing such education, the program shall ensure that key information is continuously and readily available or visible to students through posters, student handbooks, or other written formats (p. 20).

PREA Posters (English/Spanish): The posters were updated during the post-on-site audit phase to a format consistent with a fifth grade reading level. 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. Additionally, the residents are able to receive access to interpretation services from the school system.

Corrective Actions:

See corrective action in standard 115.333 (a).

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 signed upon completion of the education. The auditor also reviewed 21 signed Resident Orientation Acknowledgement forms.

Corrective Actions:

See corrective action in standard 115.333 (a).

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:

Rite of Passage will not tolerate sexual abuse of any kind within our environment. We have guidelines and procedures to reduce your risk of sexual abuse and harassment. Our role is to prevent, respond, report, and investigate any and all incidents of sexual abuse and misconduct. Resident-on-Resident Sexual Abuse and Harassment is Prohibited No one has the right to use threats, intimidation, inappropriate touching, or other actions to pressure you to engage in a sexual act.

As a student, if you sexually abuse or harass another student, you will be subject to disciplinary sanctions as well as any action that law enforcement may take. Staff Sexual Misconduct is Prohibited. Staff, volunteers, interns, and contractors are not allowed to engage in sexual acts or behaviors with students. Examples include sexual advances or acts by a staff member, threats by staff for refusing sexual advances, verbal or physical conduct of a sexual nature, kissing, touching, demeaning or derogatory comments about your gender, jokes about sex or gender specific traits, or touching, attention, language or conduct of a sexual nature. Even if a student agrees to be involved with a staff member, the staff member is not allowed to participate. It is prohibited and illegal. How to Report and Incident If you are a victim of sexual abuse, assault, harassment, or staff sexual misconduct while at Rite of Passage please report it immediately! You can report: Verbally • In writing • Anonymously • Through a third party All reported incidents will be investigated. This includes incidents that just happened, as well as incidents that happened weeks, months or years ago. You may tell any staff member. It is their job to report any allegations and ensure your safety. You may also tell your probation officer, case manager, or any other trusted adult.

Contact Information Reporting Abuse Child Protective Services: 205-758-1159

Tuscaloosa County Department of Health and Human Services 205-562-6900

Confidentiality You have the right to auditory confidentiality when making phone calls to legal counsel, hotline, CPS, or advocacy groups. If you want to call your lawyer: Let your TM know in advance. The TM can only make this call for you in the TM office or designated room. A time limit will be predetermined and shared with you before the call. The TM will dial the call and ask for the specified lawyer, making sure that the intended professional is on the line. The TM must step out of the room and close the door but will keep a visual on you. If you want to speak to an advocate or call CPS: You can request to speak to an advocate or call CPS at any time by letting the Shift Supervisor/Case Manager know. As soon as possible, the SS will organize a phone call in an Admin Therapy Room (with door window) to allow privacy. The staff member will dial the call, step out of the room, close the door, and keep a visual of you.

What happens when I report an incident? Rite of Passage will investigate all allegations of sexual abuse, harassment, and staff sexual misconduct. For your protection, we may work with your placing agency, social services or law enforcement in order make sure the investigation is thorough. Specially trained individuals will be assigned to investigate promptly, thoroughly, and objectively, and gather and preserve direct and circumstantial evidence. During an investigation, consideration is given to what is in the best interest of the student, the staff, and the program in cooperation with your agency of placement. The investigation may take time, and you have the right to be updated on the outcome. You will not be punished for reporting sexual misconduct. Every effort will be made to ensure your protection.

Retaliation for Reporting Sexual Abuse, Harassment or Staff Misconduct is Prohibited

Retaliation is intimidation to prevent a student from filing a complaint or participating in an investigation. Rite of Passage prohibits anyone from interfering with an investigation, including intimidation or retaliation against witnesses. If you believe you are being unfairly treated or punished in some way because you filed a complaint or assisted in the investigation of a complaint, please report this immediately to the Program Director or other trusted adult immediately. Help is Available Rite of Passage will work with you and your probation agent or placement agency to obtain community treatment, medical and mental health services in a timely manner. If a sexual assault has occurred, seek medical attention as soon as possible. Do not shower, brush teeth or wash clothes or underclothing. This could wash away hair or bodily fluids, which are critical to evidence. Save anything that touched the abuser. Immediately report the incident to a staff person or to local law enforcement in the community. Further community services are available at no cost to you at the local Tuscaloosa Safe Center for sexual assaults. The Tuscaloosa Safe Center also provides advocacy services and support in the event of a sexual assault and need for a forensic examination. See information bulletin below. (Poster of Victim Advocacy and Emotional Support) (pgs. 17-21).

Site Review Write-Up: Observation of PREA Signage Throughout the Facility

During the site review, the auditor conducted a thorough walkthrough of the facility to actively observe all posted and printed signage related to PREA compliance, civil immigration, victim support services, and sexual abuse/harassment reporting

mechanisms. The goal of the signage review was to assess readability, accessibility, consistency, accuracy, and overall visibility for both staff and persons confined in the facility.

Signage Readability and Accessibility

Language Clarity:

The signage reviewed throughout the facility used plain, easy-to-understand language appropriate for a general audience, including individuals with limited literacy. Information on how to report sexual abuse and harassment, how to access outside victim services, and the facility's zero-tolerance policy was clearly stated.

Language Availability:

Most signage was provided in English, which staff confirmed are the most commonly spoken languages among the population. Staff also reported that translations for other languages are available upon request.

Formatting and Placement:

Signs featured large, legible font sizes with clear headers, bold formatting, and color contrast, making them accessible for individuals with low vision. Signage was generally placed at an average eye level and in locations accessible to persons using wheelchairs or other mobility aids. No signage was found to be obstructed by furniture, poorly lit areas, or hidden from view.

Condition of Signage:

The auditor did not observe any signs that were damaged, defaced, or unreadable. All posted materials were intact, free from graffiti, and clearly legible. Hotline numbers and external service contacts were clearly displayed without obstruction.

Signage Accuracy and Consistency

Current and Accurate Information:

The PREA Audit Notice was prominently posted at facility entry points and housing unit bulletin boards, and it was specific to the current audit cycle. The contact information for reporting and external support services (state rape crisis center, emotional support hotline) was consistent across all locations.

Consistency Across Facility Areas:

All observed PREA posters, victim services flyers, and reporting instructions displayed uniform contact information, terminology, and policy references. No discrepancies in provider names, phone numbers, or addresses were identified. Signs for civil immigration information were also accurate and clearly delineated their purpose.

Placement of PREA and Related Signage

The auditor observed PREA-related signage placed in all relevant and required areas, including:

Housing Units: Posters outlining reporting methods and the zero-tolerance policy

	were posted on dayroom bulletin boards and in close proximity to phones used for confidential reporting. Medical and Mental Health Areas: Signs detailing access to confidential victim support services were posted outside exam and interview rooms. Booking and Intake Area: PREA education and reporting information was available at intake, in both written and poster form. Staff Areas: Staff breakrooms and locker rooms had visible signage related to staff responsibilities under PREA and contact information for the facility's PREA Coordinator. The visibility and accessibility of this information ensured that it could be retained by both staff and individuals confined in the facility. All signage appeared to be permanent, with the exception of the audit notice, which staff confirmed is posted specifically for the audit period in accordance with PREA requirements. Informal Conversations with Staff and Persons Confined The auditor conducted informal conversations with both staff and persons confined in the facility to assess their familiarity with the posted signage: Staff Feedback: Staff were able to describe the locations of PREA signage and confirmed that the signs are a routine, permanent part of the facility environment, not just posted for audit purposes. Staff stated they refer individuals to the signage when questions arise about reporting or support. Corrective Actions: See corrective action in standard 115.333 (a). 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.
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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 PREA (Prison Rape Elimination Act)/Specialized Training-Investigations/Medica; and Mental Health
- c. Rite of Passage/Safe Environment Standards

2. Interviews:

- a. Investigative staff (1)

3. Corrective Action:

- a. Investigator Certificate

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 Rites of Passage/Safe Environments Standards states that:

Any Rite of Passage administrative investigations shall be conducted by personnel who, in addition to the general training provided to all employees pursuant to PREA Standard 115.331, have received training in conducting such investigations in confinement settings.

PROCEDURE (a) In addition to the general training provided to all employees pursuant to PREA Standard 115.331, Rite of Passage shall ensure that, to the extent the agency itself conducts sexual abuse administrative investigations, its investigators have received training in conducting such investigations in confinement settings. (b) Authorized investigators for Rite of Passage shall include Program Director (or designee) and Human Resource Managers/Directors. (c)

Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Garrity warnings, sexual abuse evidence preservation, and the criteria and evidence required to substantiate a case for administrative action or law enforcement referral. (d) Rite of Passage Human Resources and/or Site Trainer shall maintain documentation that Rite of Passage investigators have completed the required specialized training in conducting sexual abuse administrative investigations (p. 21).

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:

Issue: The following items were not completed during the audit review process: Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting and Training Curriculum.

As part of corrective action, the facility shall:

Ensure all designated investigators complete the required specialized PREA investigator training;

Maintain copies of training certificates and training rosters for all applicable staff;

Provide the auditor with completed Certificates of Completion and supporting documentation demonstrating compliance with the Specialized Training Curriculum; Compliance will be determined once the facility submits documentation verifying completion of the required specialized investigator training and demonstrates an established process for maintaining ongoing compliance with PREA Standard 115.334.

The certificate of completion for PREA: Investigating Sexual Abuse in Confinement Settings was uploaded. The investigator completed the NIC training.

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:

Training was not completed.

Interviews

Investigative staff: The staff interviewed reported that the training included all of the above.

Corrective Actions:

See corrective action for 115.334 (a).

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.

Corrective Actions:

See corrective action for 115.334 (a).

115.334 (d). Auditor is not required to audit this provision.

Overall Findings:

The auditor utilized a triangulation approach by reviewing PREA facility documentation, agency policies, on-site observations, the facility site review, operational practices, interviews with staff and residents, consultations with local and national victim advocates, and the information provided in the PREA Audit Pre-Audit Questionnaire to make compliance determinations.

Following the completion of corrective action, the facility submitted documentation verifying that all staff responsible for conducting sexual abuse investigations have successfully completed the required specialized investigator training in accordance with PREA Standard 115.334. The facility also demonstrated that an established process is in place to ensure specialized investigator training is tracked, maintained, and provided to newly assigned investigators as needed to support ongoing compliance.

Based on the review of the corrective action documentation and verification of the facility's practices, the auditor has determined that the facility is now compliant with all provisions of PREA Standard 115.334.

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: 1. Documents a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA (Prison Rape Elimination Act/Specialized Training: Investigations/ Medical and Mental Health c. Rite of Passage/Safe Environment Standards d. Specialized Training: (PREA Resource Center) PREA Medical and Mental Care Standards (3) e. Annual PREA Training (1-See 115.332) 2. Interviews f. Medical and Mental Health Staff (2) 2. Corrective Action a. Mental Health Refresher Training b. Mental Health General PREA training 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 received the training required by agency policy: 4. 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 PREA (Prison Rape Elimination Act) states that “The facility requires medical and mental health practitioners, contractors, and volunteers to complete PREA training in initial orientation and annually. This documentation is kept in the employee training record.

The facility will 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

How to preserve physical evidence of sexual abuse;

How to respond effectively and professionally to student victims of sexual abuse and sexual harassment; and

How and to whom to report allegations or suspicions of sexual abuse and sexual harassment” (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 22).

Training Curriculum: The agency employs Specialized Training: PREA Medical and Mental Care Standards (PREA Resource Center (3)). It should be noted that the staff received the training prior to the PREA audit.

Interviews

Medical and Mental Health Staff: Both staff members reported receiving specialized PREA-related training associated with responding to sexual abuse and sexual harassment allegations. Staff demonstrated understanding of preserving physical evidence, recognizing signs of abuse, responding professionally to victims, and reporting allegations. One staff member referenced extensive prior experience in medical and psychiatric settings, while another referenced training received through the organization and DYS policies.

Corrective Action:

Issue

The audit determined that medical and mental health staff did not consistently receive the required specialized PREA training upon hire, as required by Standard 115.335. While staff did complete the required training prior to the audit, the facility’s process did not ensure the training occurred during onboarding or at the time of hire, and documentation did not demonstrate consistent compliance with the timing requirement.

Corrective Action Requirements

1. Training Process Improvement

The facility shall implement procedures to ensure that all newly hired medical and mental health staff receive specialized PREA training during onboarding or orientation.

Actions Required:

Update onboarding procedures to require completion of specialized PREA medical and mental health training upon hire.

Ensure training includes the required elements under Standard 115.335 related to responding to and supporting victims of sexual abuse.

Additionally, staff shall receive agency PREA training upon hire.

Ø Corrective Action Implemented: Existing staff completed the required specialized training.

2. Training Tracking and Documentation

The facility shall implement a process to ensure the timely tracking and documentation of specialized PREA training for medical and mental health staff.

Actions Required:

Maintain documentation verifying training completion and date of completion.

Ensure training records clearly demonstrate that the training occurred at or near the time of hire.

Ø Corrective Action Implemented: Existing staff completed the required specialized training.

Ø Corrective Action Implemented: Existing staff completed the General PREA Training.

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.

Bottom of Form

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: Both medical and mental health staff indicated they do not personally conduct forensic examinations; however, they demonstrated knowledge that forensic examinations must be completed by appropriately qualified and trained professionals. Staff were aware of the need to preserve evidence, document injuries, and ensure examinations are completed in accordance with PREA requirements. One staff member also described procedures for preserving biological evidence and preventing contamination

Corrective Actions:

See corrective action in standard 115.335 (a).

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.

Bottom of Form

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 four medical and mental health staff records were reviewed and confirmed that the staff receives training as required by the standard.

Specialized Training: PREA Medical and Mental Care Standards (PREA Resource Center) (3)

Corrective Actions:

See corrective action in standard 115.335 (a).

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.

Bottom of Form

	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: Documentation was not provided. Corrective Actions: Issue: Completion of PREA training as required for all staff (115.331). See corrective action 115.335 (a) 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. Bottom of Form 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.
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115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion The auditor utilized a triangulation approach to determine compliance, including a review of PREA facility documentation, agency policies and procedures, onsite observations, facility practices, staff and resident interviews, information from local and national advocates, and the PREA Audit: Pre-Audit Questionnaire. During the initial audit, the facility was placed under corrective action due to inconsistencies in the timely completion and documentation of required risk reassessments.

	Corrective Action Completed: During the corrective action period, the facility implemented measures to strengthen its process for monitoring and completing required risk reassessments within the established timeframe. The facility provided documentation demonstrating that risk reassessments are now being completed timely and appropriately documented. The auditor reviewed a sample of records submitted during the corrective action monitoring period and verified that required reassessments were completed within the applicable timeframe. The documentation also demonstrated that the facility has established an ongoing monitoring process to identify upcoming reassessment requirements and ensure timely completion. Based on the documentation submitted, corrective measures implemented, and the auditor's verification of current practices, the facility has sufficiently addressed the deficiency identified during the initial audit. The auditor determines that the corrective action has been successfully completed, and the facility has demonstrated compliance with the applicable PREA risk reassessment requirements.
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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: PREA (Prison Rape Elimination Act)/Pre-Screening and Use of Information c. Rite of Passage/Safe Environment Standards d. Student Housing Assignment e. Risk Assessment -standard 115.341 (20) f. Sample Treatment Plans- standard 115.381 and 115.342 (20) 2. Interviews: a. PREA compliance manager b. PREA coordinator

c. Staff responsible for Risk Screening (1)

d. Director

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: PREA (Prison Rape Elimination Act) states that "Placement in the facility housing units are determined according to a resident 's age, physical stature, offense, sexualized behaviors, and other mitigating factors as determined by the appropriate supervisory team members using the information obtained during the referral review process. This will be done in accordance with Federal, State, and local laws, and licensing. Housing placement based solely on identification or status of lesbian, gay, bisexual, transgender, or intersex residents is prohibited" (p. 1-2).

Risk Assessment (20) completed. A sample of treatment plans in standard 115.381 provides documentation on the agencies' efforts to document how programming, placement, education, and housing decisions are made.

The facility has two housing units. 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 near 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.

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

Interviews

PREA Compliance Manager – Risk screening information is used to inform housing decisions, including separating residents when necessary to reduce risk and enhance safety.

Staff Responsible for Risk Screening – The interviewed staff reported that in cases where prior sexual victimization is identified, the facility incorporates trauma history into the resident's service plan and provides follow-up care, including trauma-focused group and individual therapy. These services are typically initiated within a few days of identification. Similar follow-up interventions are provided for residents with a history of sexually abusive behavior, including victim awareness interventions.

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 PREA (Prison Rape Elimination Act) states that "Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other juveniles safe, and then only until an alternative means of keeping all juveniles safe can be arranged. During any period of isolation, the facility shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Resident 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.

The facility does not use isolation, however if required every 30 days when using isolation as a last resort when less restrictive measures are inadequate to keep them or other residents safe the facility shall review to determine whether there is a continuing need for separation from general population (p. 2).

There are 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.

Interviews

Director: Isolation is not routinely used; alternative measures such as relocation or staffing adjustments are prioritized. Isolation, when used, is limited and based on individual circumstances until safe alternatives are identified.

Medical and Mental Health Staff: The staff interviewed reported that the facility does

not have a true isolation; however if separated services will continue.

Staff Responsible for Supervising Residents in Isolation: the facility does not have an isolation area.

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). No longer required.

115.342 (d). No longer required.

115.342 (e). No longer required.

115.342 (f). No longer required.

115.342 (g). No longer required.

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.

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 (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. The Rite of Passage/Safe Environment Standards states that “(i) Every 30 days, the MDT shall afford each student described in paragraph (g) of this section a review to determine whether there is a continuing need for separation from the general population” (p. 26). The facility does not use isolation, however if required every 30-days when using isolation as a last resort when less restrictive measures are inadequate to keep them or other residents safe the facility shall review to determine whether there is a continuing need for separation from general population. Interviews: Staff who Supervise Residents in Isolation – There is no isolation. 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.
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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: PREA (Prison Rape Elimination Act)/Juvenile Reporting
 - c. Rite of Passage/Safe Environment Standards
 - d. Blank Grievance Form
 - e. Resident Handbook
 - f. Grievance Form (English/Spanish)
 - g. 12 Month Grievance Logbook
 - h. DYS Grievance Policy
 - i. Investigations (3) (1 Grievance related)
2. Interviews:
 - a. Random sample of staff (7)
 - b. Random sample of residents (10)
 - c. PREA compliance manager
 - d. Resident who Reported a Sexual Abuse (2-reported sexual harassment)

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: PREA (Prison Rape Elimination Act) states that:

Reporting an Allegation of Sexual Assault

Juveniles who are victims of sexual abuse/assault/harassment have the option to

report the incident to any staff member in addition to immediate point-of-contact line staff member

Juveniles may also report sexual abuse/assault/harassment to a public or private entity, such as ADAP, that is not a part of Sequel or DYS and they can immediately forward the juvenile's report to the DYS PREA Coordinator.

Juveniles may use the DYS Form 1.28 Youth Grievance Form, available in each living unit and in the school, to report sexual abuse/harassment, or they may make a verbal report to their DYS Advocacy Representative.

Juveniles or others may report allegations via a Sexual Assault Hotline 1-855-332-1594 that may be accessed 24 hours a day.

A third-party reporting form, DYS Form 115.354 Third Party Reporting for Sexual Abuse and Sexual Assault, and Sexual Harassment, is also available on the DYS PREA website for reporting allegations (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 27).

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 also has a formal grievance process. The facility provided an example of the blank grievance form. While onsite the auditor reviewed the grievance logbook.

Resident Handbook states:

Student Grievance Procedures Staff members shall provide assistance to students when it is believed that a student shall be unable to complete the form adequately. Students may also ask for assistance from another advocate (including another student, if such assistance does not create a safety/security risk).

Policy: Rite of Passage promotes a pro-social environment that teaches appropriate communication skills in order to resolve problems swiftly and amicably at the lowest level. Students, Parents/Guardians, Placing Agencies, Authorized Representatives, and other Stakeholders shall be afforded the right to grieve any inappropriate or infringing conditions, behavior, or action of staff, volunteers, or other youth that constitute a violation of their rights. Students who choose to file a grievance shall not be subject to any disciplinary sanction or adverse action pertaining to the filing of a grievance. Procedure: 1. Notification/Acknowledgement:

Upon admission to a Rite of Passage program, students shall be advised of the Rights & Privileges and the Problem Solving/Grievance procedures during the intake process by reviewing and signing the acknowledgment (See Students Rights and Privileges Policy 600.401) and the Student Handbook. The Problem Solving/Grievance procedures shall be clearly posted in the residential living area. 2. Informal Grievance and Informal Grievance is the first step of the Problem Solving/Grievance procedure. In the event that a student believes her rights have been

violated, she is encouraged to rectify the situation by informally discussing the matter with a Rite of Passage staff member during a one on one. 3. Formal Grievance If the student is not satisfied with the outcome of the informal resolution, she may submit a Formal Grievance. Grievance Forms are located in the residential living area.

Completed Grievance Forms shall be placed by the student in the secure Grievance Box located in the designated area. Each Formal Grievance shall be classified based on the seriousness of its nature. The student will identify on the Grievance Form if the violation is a Category I or Category II. Category I Grievance Category II Grievance Category I involves less serious, non-emergency concerns including but not limited to issues such as: discrimination regarding visitation/phone calls, grooming/hygiene, clothing, cottage conditions, food service, disrespect not involving threats of harm, restrictions, complaints about an ROP staff member, etc. Category II involves serious concerns that require immediate attention that may compromise a student's immediate health, safety, or welfare. This includes but is not limited to abuse, neglect, misconduct, etc. Reviewer: Program Manager/designee • Reviewer: Compliance Manager/designee • If the pertains to the Compliance Manager it will be reviewed by the Program Director/designee. • If the pertains to the Program Manager it will be reviewed by the Compliance Director/designee. The appropriate reviewer shall document the date and time of receipt on the Grievance Form. An investigation and written response shall be completed as soon as possible, but at least within no more than 72 hours of after receipt, not to include weekends or legal holidays. 4. Sensitive and Emergency Grievances.

If the grievance is of a sensitive or emergent nature, the Grievance Form may be sealed in an envelope, addressed to the Program Director, and placed into the Grievance box. Sensitive and Emergency Grievances shall be classified as Category II. 5. Review Process To ensure timely review, designated staff will check grievance boxes daily and forward grievances within 2 hours to the appropriate reviewer. If founded, the reviewer will take corrective action, document findings on the form, and provide copies to the student file, grievance log, and student. If unfounded, the reviewer will explain the rationale to the student, document on the form, and allow the student to appeal the decision by signing the form. 6.

Appeal Process If the student is not satisfied with the decision of the reviewer, she may fill out the appeal section on the bottom of the Grievance Form and return it to the reviewer for submittal to an Appellate Officer within two hours for review: Appellate Officer for Category I Grievance: Program Director/designee Appellate Officer for Category II Grievance: Compliance Manager/designee The Appellate Officer shall provide the student with a written response to her appeal within 72 hours, excluding weekends and legal holidays. The Appellate Officer will meet with the student, review the response, and provide her a copy of the form. The students' signature on the form shall acknowledge the discussion. 7.

Quality Assurance All Grievances and Appeals shall be reviewed weekly in the Grievance Log and initially by a representative as designated by the Program Director. Grievance findings shall be used for staff training and program

implementation purposes when applicable, and KPIs shall reflect the number and whether grievances are found or unfounded. 8. Grievance Procedure for Parent/ Authorized Representative/Stakeholder: Grievance statements can be submitted during visits or by mail, with mail-in forms including a self-addressed stamped envelope.

The Program Director or designee will contact the grievant by phone within 72 hours of receipt, provide a written follow-up, document the conversation/response in the student file and locally, and use the feedback to inform continuous quality improvement. Civil Rights Grievances If the grievance also alleges a civil rights violation, the Program Director (Tuscaloosa Academy for Growth and Change's Civil Rights contact) must be contacted immediately and begin investigating within seven days. Students may also file a complaint with the Alabama Department of Human Resources at 334-242 1310 or by writing to the Alabama Department of Human Resources, 50 North Ripley Street Montgomery, AL 36130 All appeals must be responded to within 72 hours by the Program Director or designee. All parties named in the grievance are to be contacted regarding the outcomes of the grievance (pgs. 19-22).

Site Review Summary

Signage, Internal Reporting Methods, Mail Process, and Record Storage

Signage

During the site review, the auditor observed a variety of posted and printed signage throughout the facility, including housing units, program areas, visitation spaces, medical and mental health areas, and administrative offices. Signage included information on PREA reporting procedures, outside victim support services, the PREA audit notice, civil immigration resources, and agency zero-tolerance policies.

Language & Accessibility: The signage was clear, concise, and written at an age-appropriate and accessible reading level for the population. Signs were available in English and other languages most commonly spoken at the facility. Font size, layout, and placement were appropriate for visibility, including by persons who may be visually impaired or use mobility devices. The auditor observed Spanish signage.

Placement: Information was consistently placed in high-traffic areas, including near phones, kiosks, program rooms, and entry points to ensure regular visibility and access. Locations afforded reasonable privacy for review, particularly those related to reporting procedures.

Condition & Accuracy: Signage was in good condition—legible, undamaged, and free of graffiti or tampering. Contact information for reporting and support services was consistent across postings, and audit notices reflected the current audit cycle.

Informal Conversations: Both staff and residents confirmed the signage is permanent (except for audit-specific notices) and readily accessible. Residents were able to identify PREA-related postings and understood their general content and

purpose.

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 should also be noted that the residents reported that some of the signage was affixed shortly before the onsite audit.

Testing Internal Reporting Methods for Confined Persons

Internal Reporting:

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:

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.

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:

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

Verbal Reporting:

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.

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:

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 residents reported that staff will provide them envelopes for mail.

Incoming Mail:

Incoming mail follows a similar process. The director 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.

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 facility leadership.

Record Storage

Risk Screening Process:

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:

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 that residents can privately report sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, or staff neglect or violations of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment. The various methods for which they can report include telling any staff member, write a grievance, write a note to a staff member they trust, or speak to DYS. Additionally, it was reported that they can contact the hotline number posted around the facility, however the staff would have to dial the number.

Resident Interview Questionnaire: The interviewed residents reported that they could report any sexual abuse or sexual harassment by notifying staff, family, or their probation officer.

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:

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 (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: PREA (Prison Rape Elimination Act) states that:

Reporting an Allegation of Sexual Assault

Juveniles who are victims of sexual abuse/assault/harassment have the option to report the incident to any staff member in addition to immediate point-of-contact line staff member

Juveniles may also report sexual abuse/assault/harassment to a public or private entity, such as ADAP, that is not a part of Sequel or DYS and they can immediately forward the juvenile's report to the DYS PREA Coordinator.

Juveniles may use the DYS Form 1.28 Youth Grievance Form, available in each living unit and in the school, to report sexual abuse/harassment, or they may make a verbal report to their DYS Advocacy Representative.

Juveniles or others may report allegations via a Sexual Assault Hotline 1-855-332-1594 that may be accessed 24 hours a day.

A third-party reporting form, DYS Form 115.354 Third Party Reporting for Sexual Abuse and Sexual Assault, and Sexual Harassment, is also available on the DYS PREA website for reporting allegations (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 24).

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 (see 115.351 a)

Site Review Summary

Signage, Internal Reporting Methods, Mail Process, and Record Storage

Signage

During the site review, the auditor observed a variety of posted and printed signage throughout the facility, including housing units, program areas, visitation spaces, medical and mental health areas, and administrative offices. Signage included information on PREA reporting procedures, outside victim support services, the PREA audit notice, civil immigration resources, and agency zero-tolerance policies.

Language & Accessibility: The signage was clear, concise, and written at an age-appropriate and accessible reading level for the population. Signs were available in English and other languages most commonly spoken at the facility. Font size, layout, and placement were appropriate for visibility, including by persons who may be visually impaired or use mobility devices.

Placement: Information was consistently placed in high-traffic areas, including near phones, program rooms, and entry points to ensure regular visibility and access. Locations afforded reasonable privacy for review, particularly those related to reporting procedures.

Condition & Accuracy: Signage was in good condition—legible, undamaged, and free of graffiti or tampering. Contact information for reporting and support services was consistent across postings, and audit notices reflected the current audit cycle.

Informal Conversations: Staff confirmed the signage is permanent (except for audit-specific notices) and readily accessible. Residents were able to identify PREA-related postings and understood their general content and purpose. However, residents reported that the signage was affixed shortly before the onsite audit.

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.

Testing Internal Reporting Methods for Confined Persons

Internal Reporting:

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:

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.

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:

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

Verbal Reporting:

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.

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:

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.

Incoming Mail:

Incoming mail follows a similar process. The leadership 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.

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:

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:

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 – Residents are provided access to external reporting resources, including advocacy services and posted hotline information. The facility provides mechanisms for anonymous reporting, such as grievance boxes, allowing residents to submit concerns confidentially.

Resident Interview Questionnaire: The interviewed residents reported that they could report an allegation of sexual abuse or sexual harassment that happened to them or someone else by telling staff, telling parents, or write a grievance. When asked if there was someone outside of the facility, they could make a report to, residents, stated parent, family member, or probation officer. All youth stated they are allowed to make a report without having to give their name.

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 (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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "The program shall provide a method for staff to privately report sexual abuse and sexual harassment of students. Staff shall adhere to the following: 1. Regardless of its source, staff, contractors and/or volunteers who receive information concerning a student and sexually abusive behavior, or who observe an incident of sexually abusive behavior, or who have a reasonable cause to suspect that student has been or is being subject to sexually abusive behavior must immediately report such to his/her supervisor and the shift supervisor and/or designee" (p. 27).

PREA Investigations: The auditor reviewed the investigations, and it was determined that allegations were documented.

Interviews

Random Sample of Staff: The interviewed staff reported that when a resident alleges sexual harassment, can he/she do so verbally, in writing, anonymously and through third parties. Such reports can be made immediately.

Resident Interview Questionnaire: The interviewed residents reported that they could make a report of sexual abuse or sexual harassment either in person or in writing. All but three youth stated they are allowed to make a report without having to give their name.

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: Residents can report sexual abuse or harassment through multiple channels, including grievance forms and direct communication with staff or leadership.

Resident who Reported a Sexual Abuse: The interviewed resident reported that a staff did assist by giving them the necessary documents to report a sexual abuse. During the audit period no resident reported a sexual abuse. Two residents did report sexual harassment and stated that staff had not spoken to them regarding the 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.

115.351 (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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that, "The program shall provide a method for staff to privately report sexual abuse and sexual harassment of students. Staff shall adhere to the following: 1. Regardless of its source, staff, contractors and/or volunteers who receive information concerning a student and sexually abusive behavior, or who observe an incident of sexually abusive behavior, or who have a reasonable cause to suspect that student has been or is being subject to sexually abusive behavior must immediately report such to

	his/her supervisor and the shift supervisor and/or designee” (p. 27). 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. Based on analysis, the facility is compliant with all provisions in this standard.
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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: PREA (Prison Rape Elimination Act)/PREA First Responder Emergency Grievance Procedure c. Rite of Passage/Safe Environment Standards d. Grievances Reviewed (12 months)

a. Grievance Form (English/Spanish)

b. DYS Grievance Policy

2. Interviews:

a. DYS Advocate

b. Resident who Reported a Sexual Abuse/Harassment (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 has an administrative process for dealing with resident grievances regarding sexual abuse and is not exempt from this standard.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "Rite of Passage programs will follow the Student Grievance Process to address allegations of sexual abuse. Rite of Passage will provide upon admission of the student, a copy of the student's rights and privileges which includes freedom from sexual abuse and harassment" (p. 28)

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:

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that “(1) The program shall not impose a time limit on when a student may submit a grievance regarding an allegation of sexual abuse. (2) The program may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse. (3) The program shall not require a student 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 program’s ability to defend against a lawsuit filed by a student on the ground that the applicable statute of limitations has expired” (p. 28).

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:

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 (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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "The program shall ensure that: (1) A student 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" (p. 28).

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:

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 (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: 1. 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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "The program 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 program shall notify the student in writing of any such extension and provide a date by which a decision will be made." (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 filing of the Grievance". "Computation of the time period excludes time utilized by Youth in preparing any administrative appeal" (p. 8).

Sexual Abuse Grievance: There were three identified sexual abuse grievances that were reviewed and investigated. The grievances are currently being investigated by an external investigator.

Interviews:

Residents who Reported a Sexual Abuse: Two resident reported sexual harassment and stated that no staff have spoken with them about the incident.

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: 1.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

If a third party, other than a parent or legal guardian, files such a request on behalf of a student, the program 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.

If the student declines to have the request processed on his or her behalf, the program shall document the student's decision.

A parent or legal guardian of a student shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such student. Such a

grievance shall not be conditioned upon the student agreeing to have the request filed on his or her behalf. Third parties, including fellow students, staff members, family members, attorneys, and outside advocates, shall be permitted to assist students in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of students (pp. 28-29)

“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 filing grievances that allege sexual abuse (p. 8).

12-month grievances (reviewed onsite)

Site Review Summary

Signage, Internal Reporting Methods, Mail Process, and Record Storage

Signage

During the site review, the auditor observed a variety of posted and printed signage throughout the facility, including housing units, program areas, visitation spaces, medical and mental health areas, and administrative offices. Signage included information on PREA reporting procedures, outside victim support services, the PREA audit notice, civil immigration resources, and agency zero-tolerance policies.

Language & Accessibility: The signage was clear, concise, and written at an age-appropriate and accessible reading level for the population. Signs were available in English and other languages most commonly spoken at the facility. Font size, layout, and placement were appropriate for visibility, including by persons who may be visually impaired or use mobility devices. The auditor observed Spanish signage.

Placement: Information was consistently placed in high-traffic areas, including near phones, program rooms, and entry points to ensure regular visibility and access. Locations afforded reasonable privacy for review, particularly those related to reporting procedures.

Condition & Accuracy: Signage was in good condition—legible, undamaged, and free of graffiti or tampering. Contact information for reporting and support services was consistent across postings, and audit notices reflected the current audit cycle.

Informal Conversations: Both staff and residents confirmed the signage is permanent (except for audit-specific notices) and readily accessible. Residents were able to identify PREA-related postings and understood their general content and purpose.

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.

Testing Internal Reporting Methods for Confined Persons

Internal Reporting:

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:

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.

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 and give to staff member.

Electronic Reporting:

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

Verbal Reporting:

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.

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:

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.

Incoming Mail:

Incoming mail follows a similar process. The leadership 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.

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 facility leadership

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. The website provides a phone number to make a report or make a direct report 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.

115.352 (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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

(1) The program shall establish procedures for the filing of an emergency grievance alleging that a student is subject to a substantial risk of imminent sexual abuse.

(2) After receiving an emergency grievance alleging a student is subject to a substantial risk of imminent sexual abuse, the program 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 program decision within 5 calendar days. The initial response and final program decision shall document the program's determination whether the student is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance (p. 29).

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 (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 residents alleging sexual abuse resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith: 0.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "The program

	may discipline a student for filing a grievance related to alleged sexual abuse only where the program demonstrates that the student filed the grievance in bad faith” (p. 29). The DYS policy further confirms that facilities may discipline a youth for filing a grievance related to sexual abuse/assault/harassment only where the facility demonstrates that the youth filed the grievance in bad faith” (p. 9). 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.
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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. Rite of Passage/Safe Environment Standards c. Tuscaloosa Safe Center LOA d. Tuscaloosa Safe Center Flyer e. Immigration Services Center Contact f. Student Handbook

g. Correspondence with Victim Advocacy

2. Interviews:

a. Random sample of residents (10)

b. Director

c. PREA Compliance Manager

d. Resident who Reported a Sexual Abuse (1)

3. Corrective Action

a. Update Student Handbook

b. PREA Victim Advocacy Group

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The

Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

(a) Each Rite of Passage site will provide access to support via postings, 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 program shall enable reasonable communication between students and these organizations and agencies, in as confidential a manner as possible.

(b) Each Rite of Passage site shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide students with confidential emotional support services related to sexual abuse. The program shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

(c) The program shall inform students, 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.

(d) The program shall also provide students with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

(e) When students request phone calls of this nature, they will be facilitated by Case Manager or higher position and reasonable privacy measures will be taken, while maintaining visual observation (p. 30).

Due to the new acquisition of the facility by the Rite of Passage, the facility will begin to use the following handbook. In the Tuscaloosa Academy for Growth and Change Student Handbook

Resident Handbook (see 115.333).

PREA Victim Advocacy Flyer: the PREA Victim Advocacy Flyer provides residents with information on how to contact the local victim advocacy center.

Email Correspondence with outside access to victim advocacy and emotional support services, confirmed the agency relationship with the child advocacy center and access to services.

Site Review:

Site Review Summary

Signage, Internal Reporting Methods, Mail Process, and Record Storage

Signage

During the site review, the auditor observed a variety of posted and printed signage throughout the facility, including housing units, program areas, visitation spaces, medical and mental health areas, and administrative offices. Signage included information on PREA reporting procedures, outside victim support services, the PREA audit notice, civil immigration resources, and agency zero-tolerance policies.

Language & Accessibility: The signage was clear, concise, and written at an age-appropriate and accessible reading level for the population. Signs were available in English and other languages most commonly spoken at the facility. Font size, layout, and placement were appropriate for visibility, including by persons who may be visually impaired or use mobility devices. The auditor observed Spanish signage.

Placement: Information was consistently placed in high-traffic areas, including near phones, program rooms, and entry points to ensure regular visibility and access. Locations afforded reasonable privacy for review, particularly those related to reporting procedures.

Condition & Accuracy: Signage was in good condition—legible, undamaged, and free of graffiti or tampering. Contact information for reporting and support services was consistent across postings, and audit notices reflected the current audit cycle.

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:

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 DHS.

Written Reporting:

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

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:

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

Verbal Reporting:

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.

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:

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.

Incoming Mail:

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 facility leadership.

Testing Access to Outside Emotional Support Services

During the onsite audit, the auditor assessed the facility's ability to provide timely, confidential, and equitable access to outside emotional support services for persons confined in the facility. The review focused on both physical access to telephones and the operational connectivity and responsiveness of the designated outside service provider.

Phone Access and Functionality

The auditor tested the phone designated for emotional support service calls using the same process available to residents. The phone was operational, had a clear dial tone, and successfully connected to the external support service provider listed on facility signage. However, it should be noted that such access is not direct and would be coordinated with the clinician.

The number posted was confirmed to be toll-free and accurately routed to the correct organization contracted or designated to provide outside emotional support.

A live person answered the call, and the auditor verified the organization's awareness of their role in supporting residents from the facility. The representative affirmed that they provide confidential emotional support services to incarcerated individuals and are prepared to receive calls from the population served at this location.

Availability and Accessibility

Phones were observed in housing units and other designated areas. Informal interviews with residents confirmed regular and reasonable access to phones during non-restricted hours. Resident access to phones is limited to coordination with the clinical staff.

There is no restricted housing at this site.

Facility staff reported that interpreter services are available upon request to assist residents in connecting with the provider when necessary.

Confidentiality

Phones used for emotional support calls are located in areas that afford reasonable privacy. These include private corners of the housing unit, medical and mental health offices, or other spaces with reduced visibility and audibility by staff or other residents. However, confidentiality is limited as clinical staff would coordinate the calls.

Staff reported that calls to emotional support services are monitored but not recorded.

Interviews

Random sample of residents: Three of the ten interviewed residents reported being aware of outside emotional support or advocacy services. When probed the residents' responses varied. They were not aware of specific services either, they were aware of the hotline number they could call, child advocacy information posted, rape crisis, organization called Bridge and counseling services. The residents stated that they were not provided information on outside emotional support services. One of the residents believed they could have a confidential call with outside services. Two residents stated that all calls are listened to by staff as staff have to dial the number.

Resident who Reported a Sexual Abuse/Harassment: The resident reported that they were not given mailing addresses or telephone numbers for outside services; at least not specific to the report.

Corrective Actions:

Finding:

Interviews and site review indicated gaps in resident knowledge regarding access to victim advocacy services and emotional support resources.

Corrective Action Taken:

The facility addressed this deficiency by conducting targeted group sessions with residents to provide education on available victim advocacy and emotional support services, including how to access these resources. Additionally, the facility updated the resident handbook to include clear, accessible information on victim advocacy services, emotional support options, and reporting mechanisms.

The updated handbook was redistributed and explained to residents to ensure understanding. Documentation of group sessions and acknowledgment of handbook receipt were maintained.

Compliance Determination:

Based on the corrective actions implemented, the facility has taken appropriate steps to ensure residents are informed of victim advocacy and emotional support services. Continued reinforcement through education and accessible written materials supports ongoing compliance.

115.353 (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 facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

(a) Each Rite of Passage site will provide access to support via postings, 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 program shall enable reasonable communication between students and these organizations and agencies,

in as confidential a manner as possible.

(b) Each Rite of Passage site shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide students with confidential emotional support services related to sexual abuse. The program shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

(c) The program shall inform students, 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.

(d) The program shall also provide students with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

(e) When students request phone calls of this nature, they will be facilitated by Case Manager or higher position and reasonable privacy measures will be taken, while maintaining visual observation (p. 30).

PREA Victim Advocacy Flyer: the PREA Victim Advocacy Flyer provides residents with information on how to contact the local victim advocacy center.

Email Correspondence with outside access to victim advocacy and emotional support services, confirmed the agency relationship with the child advocacy center and access to services. It was further reported that services have not been requested in the last 12 months.

Interviews

Resident Interview Questionnaire: Three of the ten interviewed residents reported being aware of outside emotional support or advocacy services. When probed the residents' responses varied. They were not aware of specific services either, they were aware of the hotline number they could call, child advocacy information posted, and counseling services. The residents stated that they were provided information on outside emotional support services. Overall, they could recall posters and contact information on the posters. Two of the residents believed they could have a confidential call with outside services if coordinated with the therapist.

Resident who Reported a Sexual Abuse: The two interviewed residents reported sexual harassment. Furthermore, the residents stated that they did not need or not aware of needing access to victim advocacy and emotional supportive 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.

115.353 (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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

(a) Each Rite of Passage site will provide access to support via postings, 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 program shall enable reasonable communication between students and these organizations and agencies, in as confidential a manner as possible.

(b) Each Rite of Passage site shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide students with confidential emotional support services related to sexual abuse. The program shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

(c) The program shall inform students, 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.

(d) The program shall also provide students with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

(e) When students request phone calls of this nature, they will be facilitated by Case Manager or higher position and reasonable privacy measures will be taken, while maintaining visual observation (p. 30).

MOU Child Advocacy Center of Walker County (CAC) provides guidance on access to

forensic medical examinations. Updated information, email correspondence, and letter of intent information states that the CAC will provide access to outside victim advocacy and emotional supportive services.

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

(a) Each Rite of Passage site will provide access to support via postings, 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 program shall enable reasonable communication between students and these organizations and agencies, in as confidential a manner as possible.

(b) Each Rite of Passage site shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide students with confidential emotional support services related to sexual abuse. The program shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

(c) The program shall inform students, 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. (d) The program shall also provide students with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. (e) When students request phone calls of this nature, they will be facilitated by Case Manager or higher position and reasonable privacy measures will be taken, while maintaining visual observation (p. 30). Interviews Director: Residents are provided timely access to attorneys and legal guardians, generally within the same day. PREA Compliance Manager: Residents are provided regular and confidential access to attorneys, including private meeting spaces and scheduled communication. Residents are provided regular and confidential access to attorneys, including private meeting spaces and scheduled communication. Resident Interview Questionnaire: When the interviewed residents were asked whether the facility allowed them to see or talk to their lawyer privately. Overall, the residents believed that the facility would allow them to see or talk to their lawyer privately since they never have spoken to their lawyer. The residents stated that they are also allowed to talk to their parents. Resident who Reported a Sexual Abuse/Harassment: The interviewed resident reported that they did not need to talk to an attorney but was not given a specific call to their parents. 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.
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	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Rite of Passage/Safe Environment Standards b. Zero Tolerance Policy Signage 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. The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision. Policy: The Rite of Passage/Safe Environment Standards states that: Programs will display a poster in the lobby/ reception/visiting areas (and any other area deemed appropriate) outlining to third parties how to report an incident of sexual abuse or harassment in regard to a student within the program. (b) Programs will have third party reporting forms available upon request from the program receptionist. Any reports of sexual abuse or harassment from a third party should be immediately referred to the Program Director/ Manager (p. 31). Site Review Summary Signage, Internal Reporting Methods, Mail Process, and Record Storage Signage During the site review, the auditor observed a variety of posted and printed signage throughout the facility, including housing units, program areas, visitation spaces, medical and mental health areas, and administrative offices. Signage included information on PREA reporting procedures, outside victim support services, the

PREA audit notice, civil immigration resources, and agency zero-tolerance policies.

Language & Accessibility: The signage was clear, concise, and written at an age-appropriate and accessible reading level for the population. Signs were available in English and other languages most commonly spoken at the facility. Font size, layout, and placement were appropriate for visibility, including by persons who may be visually impaired or use mobility devices. The auditor observed Spanish signage.

Placement: Information was consistently placed in high-traffic areas, including near phones, program rooms, and entry points to ensure regular visibility and access. Locations afforded reasonable privacy for review, particularly those related to reporting procedures.

Condition & Accuracy: Signage was in good condition—legible, undamaged, and free of graffiti or tampering. Contact information for reporting and support services was consistent across postings, and audit notices reflected the current audit cycle.

Informal Conversations: Staff confirmed the signage is permanent (except for audit-specific notices) and readily accessible. Residents stated that the signage was affixed shortly before the audit.

Informal Conversations:

With Staff and Residents:

Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents.

Testing Internal Reporting Methods for Confined Persons

Internal Reporting:

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:

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.

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:

	The facility does not currently offer electronic means for residents to report allegations of sexual abuse or harassment. Verbal Reporting: 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. 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. 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. 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. 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.
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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: PREA (Prison Rape Elimination Act)/PREA Institutional Response Plan
- c. Policy: PREA (Prison Rape Elimination Act)/PREA First Responder Emergency Grievance Procedures
- d. Rite of Passage/Safe Environment Standards
- e. Code of Alabama 26-14-3

2. Interviews:

- a. Random sample of staff (7)
- b. Medical and mental health staff (2)
- 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 to make 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 PREA (Prison Rape Elimination Act) states that "Staff must report immediately and emergently any knowledge, suspicion, or information that they receive regarding: an incident of sexual abuse or sexual harassment that occurred at the facility, whether or not it is part of the facility, retaliation against residents or

staff who reported such an incident; and/or, any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation” (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 32).

Code of Alabama 26-14-3 provides the state mandatory reporting laws.

Upon review of the investigations the auditor determined that proper notifications were made.

Interviews:

Random Sample of Staff - All of the interviewed staff reported that everyone is required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All staff reported similar policy/ procedure for reporting any information related to sexual abuse by notifying supervisor or Facility Director by going through chain of command.

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 PREA (Prison Rape Elimination Act) states that First Responder Actions is to “Report the allegation to the applicable mandatory child abuse reporting laws” (p. 1).

Additionally, SAFE Environments Policy has language to support the above (p. 32).

Code of Alabama 26-14-3 provides the state mandatory reporting laws.

Upon review of the investigations the auditor determined that proper notifications were made.

Interviews

Random Sample of Staff: Seven 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 Local Law Enforcement
- Complete an incident or grievance report
- Contact Human Resources

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 PREA (Prison Rape Elimination Act) states that:

First Responder Actions:

Separate victim and alleged perpetrator

Protect incident scene if identified

Request that the alleged victim not take any actions that would destroy physical evidence, such as washing, brushing teeth, changing clothes, urinating defecating drinking or eating. (pending forensic exam)

Ensure that the alleged abuser does not take any actions that would destroy physical evidence, such as washing, brushing teeth, changing clothes, urinating defecating drinking or eating. (pending forensic exam).

Report the allegation to the applicable mandatory child abuse reporting laws. Staff shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's investigators (PREA Compliance Manager and those trained as investigators).

When contacting Administration of the report, staff shall be prohibited 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.

Document all information and activities in an incident report

Cooperate with investigators, prosecutors, facility administration (p.1).

Additionally, SAFE Environments Policy has language to support the above (p. 32).

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:

Upon review of the investigations the auditor determined that proper notifications were made.

Interviews

Medical and Mental Health Staff: Both interviewees stated they inform residents of the limitations of confidentiality at intake and explain their duty to report allegations of sexual abuse and sexual harassment to appropriate authorities in accordance with HIPAA standards and PREA requirements. Both staff members confirmed they are mandatory reporters and are required to immediately report any knowledge, suspicion, or information regarding incidents of sexual abuse or sexual harassment to supervisors and appropriate officials in accordance with agency policy. Additionally interviewees reported being aware of incidents involving sexual abuse

allegations during their professional experience. Staff stated incidents were documented, reported immediately, and addressed according to agency policy, including supervisory notification and investigative follow-up.

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 case worker 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.

Upon review of the investigations the auditor determined that proper notifications were made.

Compliance Determination:

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

Incidents that were reported. There was one reported allegation of sexual abuse. The allegation occurred after the resident was discharged from the facility. The allegation was investigated.

Interviews

PREA Compliance Manager: Allegations are reported to appropriate authorities, including law enforcement, child welfare agencies, and facility leadership. When applicable, allegations are reported to the appropriate child welfare agency. Reports are made promptly, typically within the same day of receiving the allegation.

Director - Allegations are reported to upper management, child welfare (DHR), and local law enforcement agencies. Reports to appropriate authorities are made promptly, typically within the same day. When applicable, notifications are made in accordance with court orders and legal requirements.

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: Upon review of the investigations the auditor determined that proper notifications were made. Interviews Director: All allegations, including third-party and anonymous reports, are reported to designated investigators. Corrective Actions: 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.
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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. Rite of Passage/Safe Environment Standards 2. Interviews: a. Agency head b. Director c. Random sample of staff (7)

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "When a Rite of Passage program learns that a student is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the student" (p. 34).

Interviews

Agency Head: When a resident is identified as being at imminent risk of sexual abuse, the agency immediately separates the individuals involved and initiates an investigation. Staff are expected to respond immediately to protect residents at substantial risk of imminent sexual abuse.

Director: Residents at risk are separated and placed in safe environments. Alleged staff aggressors may be placed on administrative leave pending investigation. Staff are expected to respond immediately, typically the same day, to protect residents at risk of imminent sexual abuse.

Random Sample of Staff: The interviewed staff reported that when they learn that a resident is at risk of imminent sexual abuse the actions taken to protect the residents include remove resident from the threat, keep involved parties separated, monitor, report, and document. Such actions would be taken 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.

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.
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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. Rite of Passage/Safe Environment Standards 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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

Rite of Passage will notify the appropriate law enforcement or social services program upon receiving an allegation that a student was sexually abused while confined at another program. Rite of Passage will notify the appropriate licensing or regulatory agency upon receiving an allegation that a student was sexually harassed while confined at another program.

PROCEDURE (a) The Program Director/ Manager of the program that received the allegation shall notify the director of the program or appropriate office of the program where the alleged abuse occurred and shall also notify the appropriate law enforcement or social services program. (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. (c) The program shall document in the student's case notes that such notification has been provided. (d) The program director or program office that receives such notification shall ensure that the allegation is investigated in accordance with these standards (p. 35).

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

Rite of Passage will notify the appropriate law enforcement or social services program upon receiving an allegation that a student was sexually abused while confined at another program. Rite of Passage will notify the appropriate licensing or regulatory agency upon receiving an allegation that a student was sexually harassed while confined at another program.

PROCEDURE (a) The Program Director/ Manager of the program that received the allegation shall notify the director of the program or appropriate office of the program where the alleged abuse occurred and shall also notify the appropriate law enforcement or social services program. (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. (c) The program shall document in the student's case notes that such notification has been provided. (d) The program director or program office that receives such notification shall ensure that the allegation is investigated in accordance with these standards (p. 35).

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 (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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

	Policy: The Rite of Passage/Safe Environment Standards states that: Rite of Passage will notify the appropriate law enforcement or social services program upon receiving an allegation that a student was sexually abused while confined at another program. Rite of Passage will notify the appropriate licensing or regulatory agency upon receiving an allegation that a student was sexually harassed while confined at another program. PROCEDURE (a) The Program Director/ Manager of the program that received the allegation shall notify the director of the program or appropriate office of the program where the alleged abuse occurred and shall also notify the appropriate law enforcement or social services program. (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. (c) The program shall document in the student's case notes that such notification has been provided. (d) The program director or program office that receives such notification shall ensure that the allegation is investigated in accordance with these standards (p. 35). There were no identified allegations that required reporting to another entity. Interviews Agency Head: All allegations received are documented, and if criminal in nature, law enforcement is notified. The agency coordinates with appropriate investigative entities and supports the investigative process. There have been no recent examples of such allegations being reported from other agencies or facilities. Director: Allegations received from other facilities or agencies are investigated similarly, and such reporting has occurred. 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.
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	Auditor Overall Determination: Meets Standard Auditor Discussion The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Rite of Passage/Safe Environment Standards c. Investigations (3) 2. Interviews: a. Random sample of staff/Security Staff First Responders (7) b. Resident who reported a sexual abuse/Harassment (2) 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
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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. It should be noted that none of the reported allegations had physical evidence.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

Every Rite of Passage program will have a written plan to coordinate actions taken in response to an incident of sexual abuse. The written plan to coordinate actions will specify which entities within the program are responsible for which actions, how actions should be sequenced, and which actions can occur concurrently with other actions.

PROCEDURE The first staff member to respond to an incident shall be required to: 1. Separate the alleged victim and abuser; 2. Preserve and protect the scene until appropriate steps can be taken to collect any evidence. (Follow PREA Incident Response Flowchart and Checklist) 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. At a minimum, the follow is to be determined in the plan: 1. Assessment of the victim's acute medical needs. 2. Informing the victim of his or her rights

under relevant Federal or State law. 3. Explanation of the need for a forensic medical exam and offering the victim the option of undergoing one. 4. Offering the presence of a victim advocate or a qualified staff member to be present during the exam. 5. Providing crisis intervention counseling. 6. Interviewing the victim and any witnesses. 7. Collecting evidence. 8.

Providing for any special needs the victim may have. Investigations: Upon review, there were two reported allegations of sexual abuse and one reported allegation of sexual harassment. The two criminal investigations are ongoing.

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.

Resident who reported sexual abuse- Two residents at the facility reported sexual harassment prior to the audit. The residents stated that staff have not spoken to them about the harassment allegations. However, both residents spoke with facility director and mental health staff during the audit period.

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 one reported allegation of sexual abuse and two reported allegations of sexual harassment. All allegations were investigated.

Interviews

	Random Sample of Staff/ Security Staff and Non-Security Staff First Responders: The interviewed staff reported that if they are the first person on the scene and they have been alerted to have been a victim of sexual abuse, it is there responsibility to keep involved parties separated and contact their chain of command. When probed, staff reported that they would not share the information with other juveniles or unnecessary 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. Based on analysis, the facility is compliant with all provisions in this standard.
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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 PREA (Prison Rape Elimination Act)/Coordinated Response Plan c. Written Institutional Plan 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. Written Institutional Plan constructed from DYS contains the coordinated actions taken to respond to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Interviews Director: The facility follows a coordinated response plan involving first responders, medical/mental health staff, investigators, and leadership from start to finish of the 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. 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.
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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 is not 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.
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	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: PREA (Prison Rape Elimination Act)/Protection Against Retaliation c. Rite of Passage/Safe Environment Standards d. Monitor for Retaliation (2) 2. Interviews: a. Agency head b. Director c. Designated staff member charged with monitoring retaliation (1) 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 PREA (Prison Rape Elimination Act) states that “To ensure that residents at the facility are protected from retaliation due to a report of sexual abuse/rape or harassment. When a resident is subject to a substantial risk of imminent sexual abuse, the facility will take immediate action to protect the resident (p. 1). Additionally, SAFE Environments Policy has language to support the above (p. 37). Corrective Actions: N/A. There are no corrective actions for this provision.
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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:

Monitoring for Retaliation: the auditor reviewed three allegations that were investigated all allegations to include sexual harassment was monitored for retaliation. Monitoring occurred for 90 days.

Interviews

Agency Head: The agency protects against retaliation by separating involved individuals, transferring residents if needed, and closely monitoring staff and resident interactions. Retaliation is prohibited under a zero-tolerance policy, and staff found engaging in retaliation are subject to termination.

Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non-varied): The designated staff member (Program Director) reports actively monitoring residents and staff following reports of sexual abuse to ensure no retaliation occurs. Measures include maintaining confidentiality, separating victims from alleged aggressors, and monitoring interactions. Administrative actions such as staff reassignment or resident movement may be used when necessary to mitigate risk. The staff member confirms ongoing and direct contact with residents who report sexual abuse, indicating active follow-up and engagement.

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/harassment: The one interviewed resident reported that she feels safe because the resident that was harassing her was moved to another location. One interviewed resident reported that she do not feel safe because the accused resident is still on her unit.

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.

115.367 (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 PREA (Prison Rape Elimination Act) states that “The facility will ensure the PREA Compliance Manager will monitor the victim of the sexual abuse report for 90 days after the investigation has concluded. PREA Compliance Manager or designee will note in the communication Log the emotional and physical well-being of the resident. Any documentation related to the facility employee will be kept in the employee’s personnel file” (p. 2).

Additionally, SAFE Environments Policy has language to support the above (p. 37).

Monitoring for Retaliation: The auditor reviewed the allegations and there was one allegation of sexual abuse that was reported after the resident left the facility. However, the auditor is concerned regarding the facility response to why monitoring did not occur. Additional training is needed with the facility leadership to ensure they are aware of the requirements for monitoring for retaliation.

Interviews

Director: Protective measures include monitoring interactions, separating individuals, and placing staff on administrative leave when appropriate.

Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The staff member monitors for signs such as withdrawal, behavioral changes, or staff/resident bullying. Monitoring tools include review of camera footage, audio, and behavioral indicators such as sleep patterns and overall conduct. Monitoring of individuals who report sexual abuse continues for the entire duration of their stay at the facility. If concerns of retaliation remain, monitoring continues throughout the individual’s time at the facility, with no defined maximum

timeframe.

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.

115.367 (d). In the case of residents, such monitoring shall also include periodic status checks. There were zero allegations of sexual abuse that occurred in the last 12 months.

Compliance Determination:

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

Monitoring for Retaliation: The auditor reviewed the allegations and there was one allegation of sexual abuse that was reported after the resident left the facility. However, the auditor is concerned regarding the facility response to why monitoring did not occur. Additional training is needed with the facility leadership to ensure they are aware of the requirements for monitoring for retaliation.

Interviews

Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The staff member monitors for signs such as withdrawal, behavioral changes, or staff/resident bullying. Monitoring tools include review of camera footage, audio, and behavioral indicators such as sleep patterns and overall conduct.

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.

115.367 (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:

Interviews

Agency Head: If fear of retaliation is expressed, the agency takes proactive measures such as separating individuals, adjusting staff schedules, transferring staff

	or residents if needed, increasing supervisory oversight, and conducting unannounced rounds to monitor for potential retaliation. Director: Suspected retaliation is investigated promptly. 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. 115.367 (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. Based on analysis, the facility is compliant with all provisions in this standard.
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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. Rite of Passage/Safe Environment Standards 2. Interviews: a. Director b. Staff who supervise residents in isolation c. Medical and mental health staff (2) 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.

The number of residents who allege to have suffered sexual abuse who were placed in isolation in the past 12 months: 0.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

Rite of Passage programs shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for student with the goal of keeping all student safe and free from sexual abuse. Any student who is alleged to have suffered sexual abuse may be provided alternative housing subject to the requirements of PREA Standard 115.342. PROCEDURE (a) Students may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other student safe, and then only until an alternative means of keeping all students safe can be arranged. During any period of isolation, programs shall not deny students daily large-muscle exercise and any legally required educational programming or special education services. Students in isolation shall receive daily visits from a medical or mental health care clinician. Students shall also have access to other programs and work opportunities to the extent possible. (b) Lesbian, gay, bisexual, transgender, or intersex students shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall programs consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. (c) In deciding whether to assign a transgender or intersex students to a program for male or female students, and in making other housing and programming assignments, the program shall consider on a case-by-case basis whether a placement would ensure the student's health and safety, and whether the placement would present management or security problems. (d) Placement and programming assignments for each transgender or intersex student shall be reassessed at least twice each year to review any threats to safety experienced by the students. (e) A transgender or intersex student's own views with respect to his or her own safety shall be given serious consideration. (f) Transgender

	and intersex students shall be given the opportunity to shower separately from other students. (g) If a student is isolated pursuant to paragraph (b) of this section, the program shall clearly document: (1) The basis for the program's concern for the student's safety; and (2) The reason why no alternative means of separation can be arranged. (h) Post-allegation decisions regarding student housing will be reviewed by the MDT members. (i) Every 30 days, the MDT shall afford each student described in paragraph (g) of this section a review to determine whether there is a continuing need for separation from the general population (pp. 39-40). Interviews Director: No recent instances of isolation for protection purposes were reported. Isolation is not routinely used; alternative measures such as relocation or staffing adjustments are prioritized. Isolation, when used, is limited and based on individual circumstances until safe alternatives are identified. Medical and Mental Health Staff: Both interviewees confirmed residents placed in isolation continue to receive visits and services from medical and mental health clinicians. Staff stated visits occur regularly or daily as needed to monitor resident safety, medical status, and overall well-being in accordance with PREA standards and facility policy. Staff who Supervise Residents in Isolation – The facility does not have a true isolation area. 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.
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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. Rite of Passage/Safe Environment Standards
 - c. Investigations (3)
2. Interviews:
 - a. Investigative staff
 - b. Director
 - c. PREA coordinator
 - d. PREA Compliance Manager
 - e. Resident who Reported a Sexual Abuse (2-reported sexual harassment)
3. Corrective Action
 - a. Certificate of Completion PREA: Investigating Sexual Abuse Allegations

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "POLICY Rite of Passage facilities do not conduct criminal investigations. When a Program Director (or designee) conducts his/her own administrative investigation into allegations of sexual abuse and sexual harassment, s/he shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports" (p. 41).

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:

Training has not been conducted as of the date of the interim report.

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 self-completed with the PREA training material.

Corrective Actions:

Training: the identified staff shall complete the specialized training for investigator.

The certificate of completion for PREA: Investigating Sexual Abuse in Confinement Settings was uploaded. The investigator completed the NIC training.

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: Three allegations were reported. One was for sexual abuse and two for sexual harassment. The reported allegation of sexual abuse was reported after the youth was discharged from the program. An outside investigation

occurred along with an administrative investigation.

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.

Interviews

Investigative Staff: The investigator described a process that includes interviews, evidence gathering, and documentation of statements to support findings. Initial steps include securing the scene, separating involved parties, notifying appropriate personnel, and beginning evidence collection without delay. Evidence collected includes physical and DNA evidence, electronic monitoring (camera footage), and interviews. SAFE/SANE involvement is noted when applicable.

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "Rite of Passage shall not terminate an investigation solely because the source of the allegation recants the allegation" (p. 41).

Interviews

Investigative Staff: The staff interviewed reported that an investigation would not terminate if the source of the allegation recants their allegation.

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 Reports: Three allegations were reported. One was for sexual abuse and two for sexual harassment. The reported allegation of sexual abuse was reported after the youth was discharged from the program. An outside investigation occurred along with an administrative investigation.

Interviews:

Investigative Staff: Investigators consult with prosecutors when criminal conduct is suspected, ensuring appropriate legal coordination prior to compelled interviews.

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: Credibility determinations are based on evidence and consistency of statements. The investigator indicated an approach that does not automatically discredit any party. The facility does not require victims to submit to polygraph or truth verification examinations as a condition of proceeding with an investigation.

Residents who Reported a Sexual Abuse/Harassment: The two interviewed residents reported that they were not polygraphed.

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:

Compliance Summary – Investigative Reports, Record Retention, and Case Records Interviews

Investigative Staff: Administrative investigations include interviews, review of camera footage, and documentation of findings to determine whether staff actions contributed to the incident. Written reports include statements, evidence reviewed, and investigative findings. Documentation reflects what was reviewed and considered.

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 (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 Reports: Three allegations were reported. One was for sexual abuse and two for sexual harassment. The reported allegation of sexual abuse was reported after the youth was discharged from the program. An outside investigation occurred along with an administrative investigation.

Interviews

Investigative Staff: Criminal investigations are documented thoroughly, including physical, testimonial, and documentary evidence.

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: Cases are referred for prosecution when allegations appear substantiated and meet criminal thresholds.

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 agency shall retain all written reports referenced in paragraphs (g) and (h) of this section 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.

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The

Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that “Rite of Passage shall retain all written reports referenced in paragraphs (c) and (f) of this section for as long as the alleged abuser is incarcerated or employed by the Rite of Passage, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention” (p. 41).

Investigation Reports: Three allegations were reported. One was for sexual abuse and two for sexual harassment. The reported allegation of sexual abuse was reported after the youth was discharged from the program. An outside investigation occurred along with an administrative 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.

115.371 (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:

Investigation Reports: Three allegations were reported. One was for sexual abuse and two for sexual harassment. The reported allegation of sexual abuse was reported after the youth was discharged from the program. An outside investigation occurred along with an administrative investigation.

Interviews

Investigative Staff: Investigations continue even if a staff member resigns or is terminated prior to completion. Investigations continue even if the victim is no longer housed 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.

115.371 (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: The facility maintains communication with outside investigators and follows up until investigations are concluded. The facility maintains communication with outside investigators and follows up until investigations are concluded.

PREA Coordinator - The interviewed PREA Coordinator reported that external law enforcement agencies conduct criminal investigations, with facility leadership maintaining communication to track case status and updates.

PREA Compliance Manager: The facility maintains communication with external investigative agencies and conducts follow-up to remain informed of case progress and outcomes.

Investigative Staff: When outside agencies investigate, facility staff cooperate by sharing information and supporting the investigative 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.

Overall Findings:

The auditor utilized a triangulation approach by reviewing PREA facility documentation, agency policies, on-site observations, the facility site review, operational practices, interviews with staff and residents, consultations with local and national victim advocates, and the information provided in the PREA Audit Pre-Audit Questionnaire to make compliance determinations.

During the corrective action period, the facility submitted documentation verifying that the designated investigator successfully completed the required specialized training for conducting sexual abuse and sexual harassment investigations in accordance with PREA requirements. The auditor reviewed the training records and confirmed that the investigator has received the specialized knowledge and skills necessary to conduct these investigations.

Based on the review of the corrective action documentation and verification of the completed training, the auditor has determined that the facility is now compliant with all provisions of this standard.

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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. Rite of Passage/Safe Environment Standards c. Investigations (3) 2. Interviews: a. Investigative staff 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. The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision. Policy: The Rite of Passage/Safe Environment Standards states that “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’ (p. 43). Investigations: documentation of administrative findings were reviewed for proper standard of proof. The documentation was detailed to include statements.

	Interviews Investigative Staff: Substantiation decisions are based on the preponderance of evidence, including statements, physical evidence, and corroborating information. 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.
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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. Rite of Passage/Safe Environment Standards c. Investigations (3) 2. Interviews: a. Director b. Investigative staff c. Resident who Reported a Sexual Abuse 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: 1. 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. Investigation was unfounded.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "Following an investigation into a student's allegation of sexual abuse suffered in a program, the program shall inform the student as to

Interviews

Director: Residents are notified of investigation results (substantiated, unsubstantiated, or unfounded).

Investigative Staff: Residents are notified of the outcome of investigations (substantiated, unsubstantiated, or unfounded). Notifications are conducted appropriately, with advocacy support present when needed.

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: 1. 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.

Investigation Reports: Investigations (3) were conducted, to include investigation reports from outside entities.

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

Following a student's allegation that a staff member has committed sexual abuse against the student, the program shall subsequently inform the student (unless the program has determined that the allegation is unfounded) whenever: (1) The staff

member is no longer posted within the student's unit; (2) The staff member is no longer employed at the program; (3) The program learns that the staff member has been indicted on a charge related to sexual abuse within the program; or (4) The program learns that the staff member has been convicted on a charge related to sexual abuse within the program (p. 44).

Interviews:

Resident who Reported a Sexual Abuse: There were no identified residents who reported a sexual abuse involving 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.

115.373 (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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

Following a student's allegation that he or she has been sexually abused by another student, the program shall subsequently inform the alleged victim whenever: (1) The program learns that the alleged abuser has been indicted on a charge related to sexual abuse within the program; or (2) The program learns that the alleged abuser has been convicted on a charge related to sexual abuse within the program. There was one allegation where notification was made; two allegations are pending (p. 44).

Interviews:

Resident who Reported a Sexual Abuse/Harassment: The interviewed residents reported they have not been told of the results of the investigation and unaware of an investigation due to no staff speaking to them about the allegation. However, one resident reported that as of the date the other involved resident was not moved, and they reside in the same housing unit.

Corrective Actions:

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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-onsite phase. The Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that "All such notifications or attempted notifications shall be provided to the student in writing on a "Post Allegation Student Notification Response Form" by the Program Director (or designee) and kept in the student file. (see Form in Appendix of Safe Environmental Standards Binder)" (p. 44).

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: PREA (Prison Rape Elimination Act)/Disciplinary Sanctions for Staff c. Rite of Passage/Safe Environment Standards d. Investigation (3) 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 PREA (Prison Rape Elimination Act) states that: The facility has a zero-tolerance policy relating to sexual assault/harassment of a resident. Any employee accused of assault or harassment will comply with any and all investigations both internal and external. Outlined below are the discipline steps involved in any and all allegations. The facility reserves the right to combine or skip steps depending upon facts of each situation and the nature of the offense. Factors that will be considered depend upon the severity of the allegation. Nothing in this policy provides any contractual rights regarding employee discipline nor should anything in this policy be read or construed as modifying or altering the employment-at-will relationship between the facility and its employees Procedure: Step 1: Administrative Leave with Pay: · In the event of a resident allegation of sexual assault/harassment against an employee of the facility, the employee will be placed on Administrative Leave with pay pending an investigation of the allegation.

- This leave will be administered by the Human Resources Director (or Executive Director if HR is not available). Contact between the Human Resources Director and the employee will occur on a weekly basis.
- Upon completion of the investigation; exoneration, disciplinary action or termination will be determined.
- Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.
- In the event of exoneration, the employee will be returned to work as soon as possible.

Step 2: Written Warning:

- If upon completion of an investigation, whether internal or external, the conclusion recommends disciplinary action, a written warning will be administered by the Human Resources Director (or the Executive Director in the absence of HR) and placed in the employee's personnel file. A written warning involves formal documentation of the performance or conduct and consequences.
- The Human Resources Director will outline the consequences for the employee of his or her continued failure to meet performance and/or conduct expectations. The warning will also outline that any further actions will result in further discipline up to and including termination

Step 4: Recommendation for Termination of Employment:

- If upon completion of an investigation, whether internal or external, the conclusion recommends termination of employment, the employee will be contacted by the Human Resources Director (or Executive Director in the absence of HR) to discuss the findings of the investigation and notify the employee of employment termination to be effective immediately.
- When possible, the employee will meet with HR and PREA Compliance Manager in person to discuss the findings and sign termination paperwork.
- If, upon completion of an investigation, a determination of criminal conduct is concluded, the proper law enforcement authorities will be contacted by the Executive Director.

Policy: The Rite of Passage/Safe Environment Standards states that:

Staff shall be subject to disciplinary sanctions up to and including termination for violating program sexual abuse or sexual harassment policies. PROCEDURE (a) (b) (c) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Disciplinary sanctions for violations of program 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. All terminations for violations of program 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 and social services agencies (p. 45).

There were two reported allegations where disciplinary action was taken. The disciplinary action was documented.

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: 2. 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: 2.

Policy: The PREA (Prison Rape Elimination Act) states that:

- If upon completion of an investigation, whether internal or external, the conclusion recommends termination of employment, the employee will be contacted by the Human Resources Director (or Executive Director in the absence of HR) to discuss the findings of the investigation and notify the employee of employment termination to be effective immediately.
- When possible, the employee will meet with HR and PREA Compliance Manager in person to discuss the findings and sign termination paperwork.
- If, upon completion of an investigation, a determination of criminal conduct is concluded, the proper law enforcement authorities will be contacted by the Executive Director (p. 2).

Policy: The Rite of Passage/Safe Environment Standards states that:

Staff shall be subject to disciplinary sanctions up to and including termination for violating program sexual abuse or sexual harassment policies. PROCEDURE (a) (b) (c) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Disciplinary sanctions for violations of program 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. All terminations for violations of program 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 and social services agencies (p. 45).

There were two reported allegations where disciplinary action was taken. The disciplinary action was documented.

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 Rite of Passage/Safe Environment Standards states that:

Staff shall be subject to disciplinary sanctions up to and including termination for violating program sexual abuse or sexual harassment policies. PROCEDURE (a) (b) (c) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Disciplinary sanctions for violations of program 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. All terminations for violations of program 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 and social services agencies (p. 45).

There were two reported allegations where disciplinary action was taken. The disciplinary action was documented.

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 PREA (Prison Rape Elimination Act) states that "If upon completion of an investigation, whether internal or external, the conclusion recommends termination of employment, the employee will be contacted by the Human Resources Director (or Executive Director in the absence of HR) to discuss the findings of the investigation and notify the employee of employment termination to be effective immediately. When possible, the employee will meet with HR and PREA Compliance Manager in person to discuss the findings and sign termination paperwork. If, upon completion of an investigation, a determination of criminal conduct is concluded, the proper law enforcement authorities will be contacted by the Executive Director" (p. 2).

Policy: The Rite of Passage/Safe Environment Standards states that:

Staff shall be subject to disciplinary sanctions up to and including termination for violating program sexual abuse or sexual harassment policies. PROCEDURE (a) (b) (c) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Disciplinary sanctions for violations of program 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. All terminations for violations of program 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 and social services agencies (p. 45). Two allegations resulted in disciplinary action, which was documented; one led to termination. 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.
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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: PREA (Prison Rape Elimination Act)/Volunteer/Intern/Contracted Employee Discipline c. Rite of Passage/Safe Environment Standards 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 PREA (Prison Rape Elimination Act) states that “The facility has a zero-tolerance policy relating to sexual assault/harassment of a resident. Any volunteer/ intern/contracted employee accused of assault or harassment will comply with any and all investigations both internal and external. Upon commencement of an investigation, all contact between a volunteer/intern/contracted employee and residents will be prohibited until the investigation has been completed. In the event of exoneration upon conclusion of an investigation, no further action will be taken and normal responsibilities will resume. If criminal or non-criminal wrongdoing is concluded, the facility will terminate the contract of said employee or relationship with said volunteer/intern and report any criminal activity to proper law enforcement (p.1).

Policy: The Rite of Passage/Safe Environment Standards states that “Volunteers and contractors found to have participated in activity in this policy will be reported to law enforcement and social services agencies. Volunteers and contractor will also be prohibited from any further contact with any student and be denied access to any program. PROCEDURE The program shall take appropriate remedial measures and prohibit further contact with students and be denied access to any program” (p. 46).

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 PREA (Prison Rape Elimination Act) states that “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. These efforts will be documented by the Human Resources Director or designee and placed in contracted employee, intern, or volunteer files” (p. 1).

Policy: The Rite of Passage/Safe Environment Standards states that “Volunteers and contractors found to have participated in activity in this policy will be reported to law enforcement and social services agencies. Volunteers and contractor will also be prohibited from any further contact with any student and be denied access to any program. PROCEDURE The program shall take appropriate remedial measures and prohibit further contact with students and be denied access to any program” (p. 46).

There were no allegations that involved volunteers or contractors.

Interviews

Director: The facility takes corrective action and prohibits further contact when violations occur. Remedial actions include training, increased supervision, and policy 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.

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: PREA (Prison Rape Elimination Act)/Disciplinary Sanctions for Residents c. Rite of Passage/Safe Environment Standards d. Investigation Reports/Data Collection Report (3) 2. Interviews: a. Director b. Medical and mental health staff (2) 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 PREA (Prison Rape Elimination Act) states that: Disciplinary action may be administered to a resident who engages in sexual abuse under the following guidelines Disciplinary action may be administered only upon an administrative or criminal finding that the resident engaged in resident-on-resident sexual abuse. Any disciplinary action shall be commensurate with the nature and circumstances of

the abuse committed, with the resident's disciplinary history and the sanctions imposed for comparable offenses by other residents with similar histories.

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 discipline, if any, should be imposed.

Disciplinary action will only be considered for resident sexual contact with a staff member if there is an administrative or criminal finding that the staff member did not consent to such contact.

Disciplinary action will never result in resident isolation (seclusion) practices.

Residents will not lose their ability to participate in education, treatment services nor large muscle activity time.

F. The facility offers therapy, counseling, or other interventions (Trauma Focused Care) designed to address and correct the underlying reasons or motivations for 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 behavior-based incentives. These efforts must be documented by the assigned Therapist or designee.

G. The facility prohibits disciplinary actions 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 sufficient evidence to substantiate the allegation.

H. The facility will, 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" (pp. 1-2).

Policy: The Rite of Passage/Safe Environment Standards states that:

Rite of Passage promotes a safe environment with established rules that are designed to protect the students and staff. Students shall understand the program rules, as well as the consequences for not meeting them. Rule violations shall be addressed through a consistent and fair process. (See ROP Policy 600.121- Code of Conduct) PROCEDURE (a) A student will be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the student engaged in student-on-student sexual abuse or following a criminal finding of guilt for student-on-student sexual abuse. (b) Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the student's disciplinary history, and the sanctions imposed for comparable offenses by other students with similar histories. In the event a disciplinary sanction results in the isolation of a student, programs shall not deny the student large muscle exercise or access to any legally required educational programming or special education services. Students in isolation shall receive daily visits from a medical or mental health care clinician. Students shall also have access to other programs and work opportunities to the extent possible. (c) The disciplinary process shall consider whether a student's mental disabilities or mental illness contributed to his or her

behavior when determining what type of sanction, if any, should be imposed. (d) If the program offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the program shall conduct an MDT meeting to consider whether to offer the offending student participation in such interventions. The program 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. (e) The program will discipline a student for sexual contact with staff only upon a finding that the staff member did not consent to such contact. (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.

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 PREA (Prison Rape Elimination Act) states that "Disciplinary action will never result in resident isolation (seclusion) practices. Residents will not lose their ability to participate in education, treatment services nor large muscle activity time" (p. 2).

Interviews

Director: Residents found responsible for abuse may face discharge, transfer, or additional charges. Sanctions are applied proportionately and consider individual circumstances, including mental health status.

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:

Interviews

Director: Residents found responsible for abuse may face discharge, transfer, or additional charges. Sanctions are applied proportionately and consider individual circumstances, including mental health status.

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 Staff: Both staff members stated the facility provides mental health and intervention services designed to address trauma and the underlying causes associated with sexual abuse victimization and offending behaviors. Staff emphasized the importance of trauma-informed care and therapeutic intervention services. Interviewees stated residents are not required to participate in counseling or treatment services as a condition for access to rewards-based behavior management systems, programming, or education 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.

115.378 (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.

The facility did not have policy in place for this provision prior to the audit; however, the facility was acquired by the Rite of Passage during the pre-on-site phase. The

Rite of Passage has policy language to address this provision.

Policy: The Rite of Passage/Safe Environment Standards states that:

Rite of Passage promotes a safe environment with established rules that are designed to protect the students and staff. Students shall understand the program rules, as well as the consequences for not meeting them. Rule violations shall be addressed through a consistent and fair process. (See ROP Policy 600.121- Code of Conduct) PROCEDURE (a) A student will be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the student engaged in student-on-student sexual abuse or following a criminal finding of guilt for student-on-student sexual abuse. (b) Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the student's disciplinary history, and the sanctions imposed for comparable offenses by other students with similar histories. In the event a disciplinary sanction results in the isolation of a student, programs shall not deny the student large muscle exercise or access to any legally required educational programming or special education services. Students in isolation shall receive daily visits from a medical or mental health care clinician. Students shall also have access to other programs and work opportunities to the extent possible. (c) The disciplinary process shall consider whether a student's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. (d) If the program offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the program shall conduct an MDT meeting to consider whether to offer the offending student participation in such interventions. The program 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. (e) The program will discipline a student for sexual contact with staff only upon a finding that the staff member did not consent to such contact. (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 (p. 47).

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 PREA (Prison Rape Elimination Act) states that “The facility prohibits disciplinary actions 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” (p. 2).

Policy: The Rite of Passage/Safe Environment Standards states that:

Rite of Passage promotes a safe environment with established rules that are designed to protect the students and staff. Students shall understand the program rules, as well as the consequences for not meeting them. Rule violations shall be addressed through a consistent and fair process. (See ROP Policy 600.121- Code of Conduct) PROCEDURE (a) A student will be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the student engaged in student-on-student sexual abuse or following a criminal finding of guilt for student-on-student sexual abuse. (b) Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the student’s disciplinary history, and the sanctions imposed for comparable offenses by other students with similar histories. In the event a disciplinary sanction results in the isolation of a student, programs shall not deny the student large muscle exercise or access to any legally required educational programming or special education services. Students in isolation shall receive daily visits from a medical or mental health care clinician. Students shall also have access to other programs and work opportunities to the extent possible. (c) The disciplinary process shall consider whether a student’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. (d) If the program offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the program shall conduct an MDT meeting to consider whether to offer the offending student participation in such interventions. The program 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. (e) The program will discipline a student for sexual contact with staff only upon a finding that the staff member did not consent to such contact. (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 (p. 47).

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 PREA (Prison Rape Elimination Act) states that “The facility will, in its discretion, prohibit all sexual activity between resident’s 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” (p. 2).

Policy: The Rite of Passage/Safe Environment Standards states that:

Rite of Passage promotes a safe environment with established rules that are designed to protect the students and staff. Students shall understand the program rules, as well as the consequences for not meeting them. Rule violations shall be addressed through a consistent and fair process. (See ROP Policy 600.121- Code of Conduct) PROCEDURE (a) A student will be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the student engaged in student-on-student sexual abuse or following a criminal finding of guilt for student-on-student sexual abuse. (b) Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the student’s disciplinary history, and the sanctions imposed for comparable offenses by other students with similar histories. In the event a disciplinary sanction results in the isolation of a student, programs shall not deny the student large muscle exercise or access to any legally required educational programming or special education services. Students in isolation shall receive daily visits from a medical or mental health care clinician. Students shall also have access to other programs and work opportunities to the extent possible. (c) The disciplinary process shall consider whether a student’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. (d) If the program offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the program shall conduct an MDT meeting to consider whether to offer the offending student participation in such interventions. The program 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. (e) The program will discipline a student for sexual contact with staff only upon a finding that the staff member did not consent to such contact. (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 (p. 47). 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.
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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: PREA (Prison Rape Elimination Act)/Access to Emergency Medical and Mental Health Services c. Rite of Passage/Safe Environment Standards d. Follow Up Services/Individual Session prior victimization (5) e. TAGC File Access 2. Interviews a. Staff responsible for risk screening (1)

- b. Medical and Mental Health staff (2)
- c. Resident Reported a Prior Sexual Abuse (6)
- 3. Corrective Action:
 - a. Follow Up Services (13)

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-mentioned services. In the past 12 months, the percentage of residents who disclosed prior victimization during screening were offered a follow-up meeting with a medical or mental health practitioner: 100 (number 3).

Policy: The PREA (Prison Rape Elimination Act) states that "If it is indicated during the screening pursuant to Juvenile PREA Standard 115.341 that a resident has experienced prior sexual victimization (regardless of the setting), staff conducting the screening will ensure the resident is aware they may follow up on the subject with a medical professional during their new admission physical, which takes place within seven days of their admission" (p. 1).

Policy: The Rite of Passage/Safe Environment Standards states that:

(a) If the screening pursuant to PREA Standard 115.341 indicates that a student has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, the program shall ensure that the student is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. (b) If the screening pursuant to PREA Standard 115.341 indicates that a student has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the program shall ensure that the student is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. (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. (d) Medical and mental health practitioners shall obtain informed consent from students before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the student is under the age of 18. (e) Programs will conduct a mental health evaluation of all known student on student abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by qualified mental health practitioners (115.383) (p. 48)

Follow up-Individual Session: the auditor was able to review documentation of a resident who disclosed prior victimization. The documentation did not always specifically indicate that the service plan addressed prior history of sexual victimization.

Interviews

Staff Responsible for Risk Screening: The interviewed staff responsible for risk screening reported that in cases where prior sexual victimization is identified, the facility incorporates trauma history into the resident's service plan and provides follow-up care, including trauma-focused group and individual therapy. These services are typically initiated within a few days of identification. Similar follow-up interventions are provided for residents with a history of sexually abusive behavior, including victim awareness interventions.

Residents(s) in custody who Disclose Sexual Victimization at Risk Screening: Six onsite resident in custody disclosed previous sexual victimization. The four residents reported that they did receive follow up services. Two residents reported that they now see therapist and two residents reported that they refused additional services.

Corrective Actions:

Issue

During the audit, documentation was reviewed for a resident who disclosed prior sexual victimization. While follow-up services were provided, documentation did not consistently indicate that the individual service plan specifically addressed the resident's prior history of sexual victimization, as required under Standard 115.381.

Corrective Action Requirements

1. Service Plan Documentation Improvement

The facility shall ensure that when a resident discloses prior sexual victimization, the individual service plan clearly documents how the history of victimization is addressed through treatment or follow-up services. This documentation shall occur within 14 days of the completion of the risk screening.

Actions Required:

Update documentation procedures to ensure prior victimization disclosures are

clearly reflected in the resident's service plan.

Ensure medical or mental health staff document the follow-up services, counseling, or treatment recommendations related to the disclosure.

2. Staff Guidance

The facility should provide guidance or refresher instruction to medical and mental health staff responsible for developing service plans to ensure consistent documentation of follow-up services related to prior sexual abuse disclosures.

3. 90-Day Monitoring Period

The facility shall monitor resident screenings and service plans for a 90-day period to ensure documentation clearly reflects follow-up services when residents disclose prior sexual victimization.

Actions Required:

Conduct periodic reviews of resident records where prior victimization is identified. Verify that service plans include specific documentation addressing the disclosure and related services.

Documentation Required

During the 90-day corrective action period, the facility shall provide:

1. Updated procedures or guidance related to documenting prior victimization in service plans.
2. Redacted examples of resident service plans demonstrating documentation of follow-up services.
3. Documentation showing periodic review of resident records to ensure compliance during the monitoring period.

Demonstration of Compliance

At the conclusion of the 90-day corrective action period, the facility must demonstrate that resident service plans consistently document follow-up services when prior sexual victimization is disclosed, consistent with PREA Standard 115.381.

Corrective Actions were completed.

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 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 perpetrated sexual abuse, as indicated during screening, were offered a follow-up meeting with a mental health practitioner: 0. There were zero identified residents who reported a prior history of sexual perpetration.

Policy: The PREA (Prison Rape Elimination Act) states that "If it is indicated during the screening pursuant to 115.341 that the resident has previously perpetrated sexual abuse (regardless of the setting), staff conducting the screening will ensure that the resident has a follow up appointment scheduled with the facility Therapist within 14 days of the intake screening. This facility is a facility for residents with conduct behaviors that require a medium risk program that offers rehabilitative services." (p. 1).

Policy: The Rite of Passage/Safe Environment Standards states that:

(a) If the screening pursuant to PREA Standard 115.341 indicates that a student has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, the program shall ensure that the student is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. (b) If the screening pursuant to PREA Standard 115.341 indicates that a student has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the program shall ensure that the student is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. (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. (d) Medical and mental health practitioners shall obtain informed consent from students before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the student is under the age of 18. (e) Programs will conduct a mental health evaluation of all known student on student abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by qualified mental health practitioners (115.383) (p. 48)

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 facility will follow up with the therapist.

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 PREA (Prison Rape Elimination Act) states that "Any information regarding a resident related to sexual victimization or abusiveness that occurred shall be shared as necessary for the development of treatment plans, behavior support plans, safety plans, education planning, or as otherwise required by federal, state, or local law (p. 1).

Policy: The Rite of Passage/Safe Environment Standards states that:

(a) If the screening pursuant to PREA Standard 115.341 indicates that a student has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, the program shall ensure that the student is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. (b) If the screening pursuant to PREA Standard 115.341 indicates that a student has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the program shall ensure that the student is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. (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. (d) Medical and mental health practitioners shall obtain informed consent from students before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the student is under the age of 18. (e) Programs will conduct a mental health evaluation of all known student on student abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by qualified mental health practitioners

(115.383) (p. 48)

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 role 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:

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:

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.

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 PREA (Prison Rape Elimination Act) states that "Medical and mental health practitioners will 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. If a resident is over the age of 18, consent must be obtained by the facility staff prior to reporting sexual abuse that did not occur in an institutional setting” (p. 2).

Policy: The Rite of Passage/Safe Environment Standards states that:

(a) If the screening pursuant to PREA Standard 115.341 indicates that a student has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, the program shall ensure that the student is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. (b) If the screening pursuant to PREA Standard 115.341 indicates that a student has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the program shall ensure that the student is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. (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. (d) Medical and mental health practitioners shall obtain informed consent from students before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the student is under the age of 18. (e) Programs will conduct a mental health evaluation of all known student on student abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by qualified mental health practitioners (115.383) (p. 48)

Consent: two residents who reported sexual abuse.

Interviews

Medical and Mental Health Staff: Both staff members confirmed informed consent is obtained prior to reporting sexual victimization that did not occur in an institutional setting. Staff stated medical and mental health practitioners discuss consent requirements with residents and obtain appropriate authorization prior to reporting, consistent with policy and professional standards. Interviewees demonstrated understanding of the informed consent process for residents under the age of 18. Staff indicated consent procedures involve appropriate guardians, medical staff, mental health practitioners, and documentation requirements in accordance with policy and state 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 utilized a triangulation approach by reviewing PREA facility documentation, agency policies, on-site observations, the facility site review, operational practices, interviews with staff and residents, and supporting documentation submitted during the corrective action period to determine compliance with PREA Standard 115.381(a). During the corrective action period, the facility revised its documentation procedures to ensure that when a resident discloses prior sexual victimization, the resident's individual service plan clearly documents how the disclosure is addressed through treatment, counseling, and other follow-up services. The facility also provided guidance and refresher instruction to medical and mental health staff responsible for developing and updating service plans to reinforce the documentation requirements of PREA Standard 115.381(a). The auditor reviewed the updated guidance, training documentation, and multiple redacted resident records submitted during the 90-day monitoring period. The records demonstrated that residents who disclosed prior sexual victimization received timely follow-up by qualified medical or mental health practitioners and that the individual service plans consistently documented the services provided, treatment recommendations, and ongoing interventions. Additionally, the facility submitted evidence of periodic quality assurance reviews conducted throughout the monitoring period to verify continued compliance and ensure documentation remained consistent with PREA requirements. Based on the review of the corrective action documentation, resident records, staff guidance, quality assurance monitoring, and evidence of sustained implementation, the auditor has determined that the facility has successfully completed all required corrective actions. The facility now consistently documents follow-up services in resident service plans when prior sexual victimization is disclosed and is compliant with the requirements of PREA Standard 115.381(a).
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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: PREA (Prison Rape Elimination Act)/Access to Emergency Medical and Mental Health Services

	c. Rite of Passage/Safe Environment Standards 2. Interviews: a. Medical and mental health staff (2) b. Random Sample of Staff/Security staff and non-security staff first responders (7) c. Resident who Reported a Sexual Abuse/Harassment (2) 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: PREA (Prison Rape Elimination Act) states that "The local crisis center (in accordance with the Memorandum of Understanding) will assess the resident needs and will provide, if necessary, any medications to prevent sexually transmitted infections, assess the need for and provide, if necessary, emergency contraception and pregnancy testing. If pregnancy results from sexually abusive penetration, the center will provide timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services" (p. 2). Policy: The Rite of Passage/Safe Environment Standards states that: POLICY Student victims will have access to emergency medical and mental health services. PROCEDURE (a) Student 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. (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
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pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners. (c) Student victims of sexual abuse while in the program 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. (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. (e) A written MOU will be established by site PREA Compliance Manager for outside services for emergency and mental health services (p. 49).

There were no allegations of sexual abuse reported during the audit time frames; where the resident was still on campus. Any allegation made occurred upon the resident leaving the program.

Interviews

Medical and Mental Health Staff: Both staff members confirmed resident victims of sexual abuse receive immediate and unimpeded access to emergency medical treatment and crisis intervention services without unnecessary delay. Interviewees defined “timely” access to services as occurring immediately or as soon as possible following a report or discovery of sexual abuse to ensure residents receive prompt medical and mental health treatment. Both staff members stated the nature and scope of medical and mental health services are determined according to professional judgment, medical assessments, body audits, documentation, and individualized treatment needs.

Resident who Reported Sexual Abuse/harassment: Two resident during the onsite audit reported an allegation of sexual harassment no medical had been offered.

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; where the resident was still on campus. Any allegation made occurred upon the resident leaving the program.

Interviews

Random Sample of Staff – The interviewed staff reported that they have been trained on the agency's zero tolerance policy for sexual abuse and sexual harassment. The staff reported that the training included:

- a. The agency's zero-tolerance policy on sexual abuse and sexual harassment?
- b. How to fulfill your responsibilities regarding sexual abuse and sexual harassment prevention, detection, reporting, and response, in accordance with agency policies and procedures?
- c. Resident's right to be free from sexual abuse and sexual harassment?
- d. Residents' and employees' right to be free from retaliation for reporting sexual abuse and sexual harassments?
- e. The dynamics of sexual abuse and sexual harassment in confinement?
- f. The common reactions of sexual abuse and sexual harassment victims?
- g. How to detect and respond to signs of threatened and actual sexual abuse?
- h. How to avoid inappropriate relationship with residents?
- i. How to communicate effectively and professionally with residents, including lesbians, gay, bisexual, transgender, intersex, or gender nonconforming residents?
- j. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?
- k. Relevant laws regarding the applicable age of consent?

The staff consistently reported that they were trained on initial hire and that they received additional training a few weeks before the audit. When probed the staff were able to describe things like the common reactions of victims, what to look for, and how to respectfully talk to residents who may be lesbian, gay, bisexual, transgender or gender non-conforming.

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; where the resident was still on campus. Any allegation made occurred upon the resident leaving the program.

Interviews

Medical and Mental Health Staff: Both interviewees confirmed victims of sexual abuse are provided timely information and access to emergency contraception and sexually transmitted infection prophylaxis when medically appropriate and consistent with professional standards of care.

Resident who reported sexual abuse/harassment: The interviewed resident did not report 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 (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: PREA (Prison Rape Elimination Act) states that "All medical and mental health services provided to a resident will be at no cost to the victim. All other treatment

	services provided will be at no cost to the victim” (p. 3). Policy: The Rite of Passage/Safe Environment Standards states that: POLICY Student victims will have access to emergency medical and mental health services. PROCEDURE (a) Student 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. (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. (c) Student victims of sexual abuse while in the program 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. (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. (e) A written MOU will be established by site PREA Compliance Manager for outside services for emergency and mental health services (p. 49). 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.
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115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:

- a. Pre-Audit Questionnaire (PAQ)
- b. Policy: PREA (Prison Rape Elimination Act)/Access to Emergency Medical and Mental Health Services
- c. Rite of Passage/Safe Environment Standards

2. Interviews:

- a. Medical and Mental Health staff (2)
- b. Resident who Reported a Sexual Abuse (2)

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: PREA (Prison Rape Elimination Act) states that:

The facility will offer the appropriate medical and mental health evaluation and treatment to any resident who has been victimized by sexual abuse in any prison, jail, lock up or juvenile facility. The facility will ensure the evaluations and treatment of such victims will include follow-up services, treatment plans, and referrals for continued care when necessary and as appropriate (p. 2).

Policy: The Rite of Passage/Safe Environment Standards states that:

Ongoing medical and mental health care will be available for sexual abuse victims

and abusers. (a) The program shall offer medical and mental health evaluation and, as appropriate, treatment to all students who have been victimized by sexual abuse. (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 the program. (c) The program shall provide such victims with medical and mental health services consistent with the community level of care. (d) Student victims of sexually abusive vaginal penetration while in the program shall be offered pregnancy tests. (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. Program Director will notify parent/guardian of test results in accordance with state and local laws. (f) Student victims of sexual abuse while in the program shall be offered tests for sexually transmitted infections as medically appropriate. Program Director will notify parent/guardian of test results in accordance with state and local laws. (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. (h) The program shall attempt to conduct a mental health evaluation of all known student-on student abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners (p. 50).

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 was two allegations of sexual harassment reported during the audit time frames; where the resident was still on campus; however, the allegation did not warrant medical attention.

Interviews

Medical and Mental Health Staff: Both staff members stated evaluation and treatment services include medical assessments, follow-up treatment, counseling, individualized treatment plans, referrals for continued care, and discharge planning when necessary. Staff also referenced referrals for outside medical services when

appropriate.

Residents who reported a sexual abuse/harassment: There was two identified resident who reported sexual harassment. The residents reported that medical and mental health did not discuss any services that may be available.

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 (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: Both interviewees confirmed medical and mental health services provided at the facility are consistent with community levels of care and professional 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.

115.383 (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:

There were no allegations involving sexual penetration.

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:

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: PREA (Prison Rape Elimination Act) states that "The local crisis center (in accordance with the Memorandum of Understanding) will assess the resident needs and will provide, if necessary, any medications to prevent sexually transmitted infections, assess the need for and provide, if necessary, emergency contraception and pregnancy testing. If pregnancy results from sexually abusive penetration, the center will provide timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services" (p. 2).

Policy: The Rite of Passage/Safe Environment Standards states that:

Ongoing medical and mental health care will be available for sexual abuse victims and abusers. (a) The program shall offer medical and mental health evaluation and, as appropriate, treatment to all students who have been victimized by sexual abuse. (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 the program. (c) The program shall provide such victims with medical and mental health services consistent with the community level of care. (d) Student victims of sexually abusive vaginal penetration while in the program shall be offered pregnancy tests. (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. Program Director will notify parent/guardian of test results in accordance with state and local laws. (f) Student victims of sexual abuse while in the program shall be offered tests for

sexually transmitted infections as medically appropriate. Program Director will notify parent/guardian of test results in accordance with state and local laws. (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. (h) The program shall attempt to conduct a mental health evaluation of all known student-on student abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners (p. 50).

Interviews

Residents who reported a sexual abuse: The interviewed residents reported that there was no sexual contact that would have required a test. Facility houses 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 (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: PREA (Prison Rape Elimination Act) states that "All medical and mental health services provided to a resident will be at no cost to the victim. All other treatment services provided will be at no cost to the victim" (p. 3).

Policy: The Rite of Passage/Safe Environment Standards states that:

Ongoing medical and mental health care will be available for sexual abuse victims and abusers. (a) The program shall offer medical and mental health evaluation and, as appropriate, treatment to all students who have been victimized by sexual abuse. (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 the program. (c) The program shall provide such victims with medical and mental health services consistent with the community level of care. (d) Student victims of sexually abusive vaginal penetration while in the program shall be offered

pregnancy tests. (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. Program Director will notify parent/guardian of test results in accordance with state and local laws. (f) Student victims of sexual abuse while in the program shall be offered tests for sexually transmitted infections as medically appropriate. Program Director will notify parent/guardian of test results in accordance with state and local laws. (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. (h) The program shall attempt to conduct a mental health evaluation of all known student-on student abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners (p. 50).

Interviews

Residents who reported a sexual abuse/harassment: The interviewed resident reported that there was no follow up medical care or services provided. There were no residents onsite 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 PREA (Prison Rape Elimination Act) states that "The facility will conduct mental health evaluations of all known resident-on-resident abusers within 60 days of learning of such abuse history. Treatment will then be offered as deemed appropriate by the mental health practitioner (p. 3).

Policy: The Rite of Passage/Safe Environment Standards states that:

Ongoing medical and mental health care will be available for sexual abuse victims and abusers. (a) The program shall offer medical and mental health evaluation and, as appropriate, treatment to all students who have been victimized by sexual abuse. (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 the program. (c) The program shall provide such victims with medical and mental health services consistent with the community level of care. (d) Student victims of sexually abusive vaginal penetration while in the program shall be offered pregnancy tests. (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. Program Director will notify parent/guardian of test results in accordance with state and local laws. (f) Student victims of sexual abuse while in the program shall be offered tests for sexually transmitted infections as medically appropriate. Program Director will notify parent/guardian of test results in accordance with state and local laws. (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. (h) The program shall attempt to conduct a mental health evaluation of all known student-on student abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners (p. 50).

Interviews

Medical and Mental Health Staff: Both staff members stated mental health evaluations are conducted for known resident-on-resident abusers when appropriate. Staff indicated evaluations occur as soon as possible after allegations are reported and may include mental health assessments, treatment referrals, documentation, and psychiatric follow-up 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.

	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: PREA (Prison Rape Elimination Act)/Sexual Abuse Incident Reviews c. Rite of Passage/Safe Environment Standards d. Blank Incident Review e. Incident Review (1) 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 PREA (Prison Rape Elimination Act) states that "The facility incident review team, along with members of the facility management team, will conduct a sexual abuse incident review within 30 days of the conclusion of the investigation. The sexual abuse incident reporting form will be utilized during this meeting. The review team will include upper-level management officials, with input from line

supervisors, investigators, and medical or mental health practitioners” (p. 1).

Policy: The Rite of Passage/Safe Environment Standards states that:

PROCEDURE (b) Complete ROP Form- Safe Environment Standards Administrative and Response Review (1) Such review shall be completed within 30 days of the conclusion of the investigation. (2) The RIIP shall report findings to site upper-level management. (3) The RIIP will submit completed SES Administrative and Response Review to the Executive Director and the CEO within 30 days of the conclusion of the investigation. (c) The site management team and RIIP 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 program; (3) Examine the area in the program 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 (b)(1)-(b)(5) of this section, and any recommendations for improvement and submit such report to Executive Director (p. 51).

There was one reported incident investigated and a incident review was conducted. This is also a reminder to the facility that the review should be conducted with a committee and not one person.

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.

Policy: The Rite of Passage/Safe Environment Standards states that:

PROCEDURE (b) Complete ROP Form- Safe Environment Standards Administrative and Response Review (1) Such review shall be completed within 30 days of the conclusion of the investigation. (2) The RIIP shall report findings to site upper-level management. (3) The RIIP will submit completed SES Administrative and Response Review to the Executive Director and the CEO within 30 days of the conclusion of the investigation. (c) The site management team and RIIP 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 program; (3) Examine the area in the program 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 (b)(1)-(b)(5) of this section, and any recommendations for improvement and submit such report to Executive Director (p. 51).

Interviews

PREA Compliance Manager: The facility completes incident review reports following investigations of sexual abuse. Reports are reviewed by leadership to ensure accountability and oversight. The facility implements corrective action plans (CAPs) to address identified issues and strengthen compliance.

Incident Review Team: The Incident Review Team reports that it considers whether incidents are motivated by protected characteristics (e.g., race, gender identity, sexual orientation, gang affiliation, or group dynamics). However, responses indicate this determination may be limited when sufficient information is not available at the time of review. The team examines the location of the incident to identify potential physical barriers that could contribute to abuse. Findings include identification of blind spots and areas with limited camera visibility, indicating environmental vulnerabilities that may require corrective action. The team assesses staffing levels at the time of the incident, including supervision adequacy across shifts. While staffing is reviewed, responses suggest concerns regarding limited staffing and supervision challenges, particularly in certain areas or times. The team evaluates the need for additional or enhanced monitoring technology. The interview reflects that camera coverage is reviewed and that additional cameras or repositioning may be necessary to address blind spots and improve supervision.

There was one reported incident investigated and a incident review was conducted. This is also a reminder to the facility that the review should be conducted with a committee and not one person.

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 does not include upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. Upon further review it was determined that the agency does have an incident review team that includes upper-level management.

Policy: The PREA (Prison Rape Elimination Act) states that "The facility incident review team, along with members of the facility management team, will conduct a sexual abuse incident review within 30 days of the conclusion of the investigation. The sexual abuse incident reporting form will be utilized during this meeting. The review team will include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners" (p. 1).

Policy: The Rite of Passage/Safe Environment Standards states that:

PROCEDURE (b) Complete ROP Form- Safe Environment Standards Administrative and Response Review (1) Such review shall be completed within 30 days of the conclusion of the investigation. (2) The RIIP shall report findings to site upper-level management. (3) The RIIP will submit completed SES Administrative and Response Review to the Executive Director and the CEO within 30 days of the conclusion of the investigation. (c) The site management team and RIIP 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 program; (3) Examine the area in the program 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 (b)(1)-(b)(5) of this section, and any recommendations for improvement and submit such report to Executive Director (p. 51).

There was one reported incident investigated and a incident review was conducted. This is also a reminder to the facility that the review should be conducted with a committee and not one person.

Interviews:

Director: The facility has an incident review team that includes upper-level management and relevant staff. Findings are used to inform training, improve practices, and strengthen investigative outcomes. The team considers contributing factors such as demographics, location, staffing levels, and monitoring technology, and evaluates whether enhancements are needed.

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) no longer required; 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 does not prepare 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. No longer required;

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.

Policy: The Rite of Passage/Safe Environment Standards states that:

PROCEDURE (b) Complete ROP Form- Safe Environment Standards Administrative and Response Review (1) Such review shall be completed within 30 days of the conclusion of the investigation. (2) The RIIP shall report findings to site upper-level management. (3) The RIIP will submit completed SES Administrative and Response Review to the Executive Director and the CEO within 30 days of the conclusion of the investigation. (c) The site management team and RIIP 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

the program; (3) Examine the area in the program 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 (b)(1)-(b)(5) of this section, and any recommendations for improvement and submit such report to Executive Director (p. 51).

There was one reported incident investigated and a incident review was conducted. This is also a reminder to the facility that the review should be conducted with a committee and not one person.

Interviews:

Director: The facility has an incident review team that includes upper-level management and relevant staff.

PREA Compliance Manager: The facility completes incident review reports following investigations of sexual abuse. Reports are reviewed by leadership to ensure accountability and oversight. The facility implements corrective action plans (CAPs) to address identified issues and strengthen compliance.

Incident Review Team: The Incident Review Team reports that it considers whether incidents are motivated by protected characteristics (e.g., race, gender identity, sexual orientation, gang affiliation, or group dynamics). However, responses

indicate this determination may be limited when sufficient information is not available at the time of review. The team examines the location of the incident to identify potential physical barriers that could contribute to abuse. Findings include identification of blind spots and areas with limited camera visibility, indicating environmental vulnerabilities that may require corrective action. The team assesses staffing levels at the time of the incident, including supervision adequacy across shifts. While staffing is reviewed, responses suggest concerns regarding limited staffing and supervision challenges, particularly in certain areas or times. The team evaluates the need for additional or enhanced monitoring technology. The interview reflects that camera coverage is reviewed and that additional cameras or repositioning may be necessary to address blind spots and improve supervision.

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 does not implement the recommendations for improvement or documents its reasons for not doing so.

Policy: The PREA (Prison Rape Elimination Act) states that "The incident review team will prepare a report of all findings and recommendations for improvement and submit it to the facility head and PREA Compliance Manager within one week of the committee's assembly. The management team will implement the recommendations for improvement or shall document its reasoning for not doing so and submit this documentation to the Quality Assurance Manager/PREA Compliance Manager for record keeping (p. 2).

Policy: The Rite of Passage/Safe Environment Standards states that:

PROCEDURE (b) Complete ROP Form- Safe Environment Standards Administrative and Response Review (1) Such review shall be completed within 30 days of the conclusion of the investigation. (2) The RIIP shall report findings to site upper-level management. (3) The RIIP will submit completed SES Administrative and Response Review to the Executive Director and the CEO within 30 days of the conclusion of the investigation. (c) The site management team and RIIP 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 program; (3) Examine the area in the program 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 (b)(1)-(b)(5) of this section, and any recommendations for improvement and submit such report to Executive Director (p. 51). There was one reported incident investigated and a incident review was conducted. This is also a reminder to the facility that the review should be conducted with a committee and not one person. 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.
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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: PREA (Prison Rape Elimination Act) c. Rite of Passage/Safe Environment Standards d. Data Collection SSV Report

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 PREA (Prison Rape Elimination Act) states that

The facility will collect and review data in the process as follows:

A. The Quality Assurance Manager will aggregate the incident-based sexual abuse data to the Quality Monitoring System (standardized instrument with definitions) on a monthly basis. This data is submitted to the Sequel Agency-Wide PREA Coordinator for review.

B. The facility will aggregate the incident-based sexual abuse data at least annually.

C. The sexual abuse incident reporting form will be completed using internally generated incident reports, formal statements, investigation files, and sexual abuse incident reviews. This information will be reflected on the form and in supporting documents. The facility will provide all data to the Department of Justice upon request.

D. The facility will maintain and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

E. The facility completes the annual Survey of Sexual Victimization for Locally or Privately-Operated Juvenile Facilities.

F. The facility management team will submit an annual report of all facility sexual abuse incident findings and corrective action plans. This report will include the identification of problems, ongoing corrective action plans, and the program's improvement and effectiveness for preventing, detecting, and responding to sexual abuse. Policies, practices, and training will also be evaluated for effectiveness and areas of improvement.

G. Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

H. The management team will use the sexual abuse incident reporting form along

with prior years' corrective action plans to produce a report assessing the agency's progress in addressing sexual abuse. The findings shall reflect any statistically relevant patterns. This report shall be submitted to the agency head within 30 days and made readily available to the public on the facility website.

I. The facility will redact any identifying information from the above-mentioned report if it poses a clear and specific threat to the safety and security of the facility or its residents. The nature of the redacted material will be indicated with the published report. The facility will not publish any personal identifiers of publicly available sexual abuse data.

J. All data collected will be retained for at least 10 years after the date of the data's initial collection on a secured electronic database as well as a hard copy in a secured location, accessible only by the management team (pp. 1-2).

Policy: The Rite of Passage/Safe Environment Standards states that:

POLICY Rite of Passage will collect accurate, uniform data for every allegation of sexual abuse at programs under its direct control. PROCEDURE (a) Each site PREA Compliance Manager shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. (b) Data collected by site PREA Compliance Managers 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. (c) Each RIIP shall aggregate the incident-based sexual abuse data at least annually. (d) Upon request, the Business Department shall provide all such data from the previous calendar year to the Department of Justice no later than June 30 (p. 52).

SSV Reports reviewed.

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.

It should be noted that this is the agencies' first PREA audit and they have not conducted an annual report or been required to report aggregate data to the state

as of the 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.

115.387 (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 PREA (Prison Rape Elimination Act) states that “The facility completes the annual Survey of Sexual Victimization for Locally or Privately-Operated Juvenile Facilities” (p. 1).

Policy: The Rite of Passage/Safe Environment Standards states that:

POLICY Rite of Passage will collect accurate, uniform data for every allegation of sexual abuse at programs under its direct control. PROCEDURE (a) Each site PREA Compliance Manger shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. (b) Data collected by site PREA Compliance Managers 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. (c) Each RIIP shall aggregate the incident-based sexual abuse data at least annually. (d) Upon request, the Business Department shall provide all such data from the previous calendar year to the Department of Justice no later than June 30 (p. 52).

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 PREA (Prison Rape Elimination Act) states that “The facility will maintain and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews” (p. 1).

Policy: The Rite of Passage/Safe Environment Standards states that:

POLICY Rite of Passage will collect accurate, uniform data for every allegation of sexual abuse at programs under its direct control. PROCEDURE (a) Each site PREA Compliance Manager shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. (b) Data collected by site PREA Compliance Managers 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. (c) Each RIIP shall aggregate the incident-based sexual abuse data at least annually. (d) Upon request, the Business Department shall provide all such data from the previous calendar year to the Department of Justice no later than June 30 (p. 52).

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 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.
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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: PREA (Prison Rape Elimination Act)/Data Collection c. Rite of Passage/Safe Environment Standards d. Website e. 2025-2026 Annual Report f. SSV Report 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: PREA (Prison Rape Elimination Act) states that the facility will “The facility management team will submit an annual report of all facility sexual abuse incident findings and corrective action plans. This report will include the identification of problems, ongoing corrective action plans, and the program’s improvement and effectiveness for preventing, detecting, and responding to sexual abuse. Policies, practices, and training will also be evaluated for effectiveness and areas of improvement” (pp. 1-2).

2025-2026 Annual Report: The purpose of the PREA annual report is to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies and practices within the agency. The report includes a review of data collected and aggregated throughout the year, identifies problem areas, takes corrective action, and provides an annual summary of findings and corrective actions for each facility as well as the agency as a whole. It also compares current year data with previous years to evaluate progress in addressing sexual abuse.

SSV Reports reviewed.

Interviews

Agency Head: The agency reviews incident-based data to identify trends and areas of concern. When increases are identified, targeted training and prevention efforts are implemented to enhance safety and reduce incidents.

PREA Coordinator: The interviewed PREA Coordinator reported that public reports exclude personally identifiable information, ensuring compliance with privacy standards such as HIPAA and maintaining confidentiality of involved parties. PREA reports are publicly available through both agency-wide and individual facility websites, supporting transparency requirements.

PREA Compliance Manager: PREA data is collected, submitted, and reviewed by

oversight entities to support compliance and continuous improvement.

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: PREA (Prison Rape Elimination Act) states that the facility will "The management team will use the sexual abuse incident reporting form along with prior years' corrective action plans to produce a report assessing the agency's progress in addressing sexual abuse. The findings shall reflect any statistically relevant patterns. This report shall be submitted to the agency head within 30 days and made readily available to the public on the facility website" (p. 2).

2026 Annual Report: The purpose of the PREA annual report is to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies and practices within the agency. The report includes a review of data collected and aggregated throughout the year, identifies problem areas, takes corrective action, and provides an annual summary of findings and corrective actions for each facility as well as the agency as a whole. It also compares current year data with previous years to evaluate progress in addressing 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.

115.388 (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. The agency reported that they were recently acquired by a new agency and the website is under review. Currently the PREA reports are in a binder.

Interviews

Agency Head: The agency head reviews annual PREA reports, but final approval is completed by the National PREA Coordinator or national leadership.

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 does not redact 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 redacted material.

2026 Annual Report: The purpose of the PREA annual report is to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies and practices within the agency. The report includes a review of data collected and aggregated throughout the year, identifies problem areas, takes corrective action, and provides an annual summary of findings and corrective actions for each facility as well as the agency as a whole. It also compares current year data with previous years to evaluate progress in addressing sexual abuse.

Interviews

PREA Coordinator: The interviewed PREA Coordinator reported that public reports exclude personally identifiable information, ensuring compliance with privacy standards such as HIPAA and maintaining confidentiality of involved parties. PREA reports are publicly available through both agency-wide and individual facility websites, supporting transparency requirements.

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.
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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: PREA (Prison Rape Elimination Act)/Data Collection c. Rite of Passage/Safe Environment Standards d. Website: Safe Standards - Rite of Passage; Safe Environmental Standards - Tuscaloosa Academy for Growth and Change 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 PREA (Prison Rape Elimination Act) states that “All data collected will be retained for at least 10 years after the date of the data’s initial collection on a secured electronic database as well as a hard copy in a secured location, accessible only by the management team” (p. 2).

Rite of Passage/Safe Environments Policy states:

Rite of Passage shall review data collected and aggregated pursuant to PREA Standard 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. PROCEDURE Data reviewed shall include the following: (a) Identifying problem areas; (1) Taking corrective action on an ongoing basis; and (2) Preparing an annual report of its findings and corrective actions for each program, as well as the organization as a whole. (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 organization’s progress in addressing sexual abuse. (c) The organization’s report shall be approved by the CEO and made readily available to the public through its website or, if it does not have one, through other means. (d) The organization may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a program but must indicate the nature of the material redacted (p. 53).

Site Review: Record Storage

During the site review, the auditor evaluated both the physical and electronic security measures in place for records maintained in compliance with the PREA Standards, including sensitive documentation such as risk screening assessments, medical and mental health records, and reports or investigations related to sexual abuse and sexual harassment.

Physical Record Storage

The facility maintains hard copy records in a designated secured storage area. The auditor observed that access to this area is restricted by lock and key, with entry limited to authorized personnel only. Sensitive documentation, including inmate PREA risk screenings, incident reports, and medical files, is stored in locked filing cabinets within a locked office or file room.

Staff confirmed that only designated personnel—such as clinical staff, investigative staff, or administrative leadership—have access to these files. The process for removing or reviewing records is tracked internally to ensure accountability and prevent unauthorized access.

Electronic Record Storage

Electronic records related to PREA compliance, including risk screening information, case tracking data, and investigative documentation, are stored within a password-protected, role-based access system. Access to these records is limited based on job function.

Informal Conversations with Staff

Through informal interviews, staff demonstrated a clear understanding of confidentiality requirements and access limitations related to sensitive PREA documentation. Staff reported that only those with a "need-to-know" are granted access to case files and related information. Mental health and medical personnel confirmed that clinical files are housed separately from general housing records and are accessible only to appropriate licensed personnel.

The facility's policies and procedures appear to be well implemented and understood by staff responsible for safeguarding PREA-related records.

Interviews

PREA Coordinator: The interviewed PREA Coordinator reported that public reports exclude personally identifiable information, ensuring compliance with privacy standards such as HIPAA and maintaining confidentiality of involved parties. PREA reports are publicly available through both agency-wide and individual facility websites, supporting transparency requirements.

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 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.

Rite of Passage/Safe Environments Policy states:

Rite of Passage shall review data collected and aggregated pursuant to PREA Standard 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. PROCEDURE Data reviewed shall include the following: (a) Identifying problem areas; (1) Taking corrective action on an ongoing basis; and (2) Preparing an annual report of its findings and corrective actions for each program, as well as the organization as a whole. (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 organization's progress in addressing sexual abuse. (c) The organization's report shall be approved by the CEO and made readily available to the public through its website or, if it does not have one, through other means. (d) The organization may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a program but must indicate the nature of the material redacted (p. 53).

Website: Safe Standards - Rite of Passage; Safe Environmental Standards - Tuscaloosa Academy for Growth and Change

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: Safe Standards - Rite of Passage; Safe Environmental Standards - Tuscaloosa Academy for Growth and Change

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 PREA (Prison Rape Elimination Act) 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). Rite of Passage/Safe Environments Policy states: Rite of Passage shall review data collected and aggregated pursuant to PREA Standard 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. PROCEDURE Data reviewed shall include the following: (a) Identifying problem areas; (1) Taking corrective action on an ongoing basis; and (2) Preparing an annual report of its findings and corrective actions for each program, as well as the organization as a whole. (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 organization’s progress in addressing sexual abuse. (c) The organization’s report shall be approved by the CEO and made readily available to the public through its website or, if it does not have one, through other means. (d) The organization may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a program but must indicate the nature of the material redacted (p. 53). Website: Safe Standards - Rite of Passage; Safe Environmental Standards - Tuscaloosa Academy for Growth and Change 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.
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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: Safe Standards - Rite of Passage; Safe Environmental Standards - Tuscaloosa Academy for Growth and Change

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 (Rite of Passage), a contractor for Alabama Division of Youth Services. It should be noted that during the initiation of the audit, the facility was operated by Brighter Path.

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 other facility PREA reports are included on the agency website. This audit serves as the first audit for 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 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 inspection 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 May 6, 2026, 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 Local Child Advocacy Center (Tuscaloosa) - 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.
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115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: Website: Safe Standards - Rite of Passage; Safe Environmental Standards - Tuscaloosa Academy for Growth and Change 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 agency's final PREA reports are published on the agency website. However, it should be noted that this is the first PREA report for the current site.

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	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.315 (f)	Limits to cross-gender viewing and searches	

	This provision is no longer applicable to your compliance finding, please select N/A.	na
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: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes

	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or 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 safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	yes
115.317 (a)	Hiring and promotion decisions	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or	yes

	coercion, or if the victim did not consent or was unable to consent or refuse?	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	yes
115.317 (b)	Hiring and promotion decisions	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes
115.317 (c)	Hiring and promotion decisions	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual	yes

	abuse or any resignation during a pending investigation of an allegation of sexual abuse?	
115.317 (d)	Hiring and promotion decisions	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes
115.317 (e)	Hiring and promotion decisions	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.317 (f)	Hiring and promotion decisions	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	Hiring and promotion decisions	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	Hiring and promotion decisions	

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

	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.)	
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	yes

	interviews?	
	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	Policies to ensure referrals of allegations for investigations	

(c)		
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes
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
	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	na
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to	yes

	mandatory reporting of sexual abuse to outside authorities?	
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes
115.331 (b)	Employee training	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.331 (c)	Employee training	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes
115.331 (d)	Employee training	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	Volunteer and contractor training	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes

115.332 (b)	Volunteer and contractor training	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.332 (c)	Volunteer and contractor training	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (a)	Resident education	
	During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes
115.333 (b)	Resident education	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	Resident education	

	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	Resident education	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	Resident education	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	Resident education	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.334 (a)	Specialized training: Investigations	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334	Specialized training: Investigations	

(b)		
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	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	Obtaining information from residents	

(a)		
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	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
	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	na
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does	yes

	the agency attempt to ascertain information about: Physical disabilities?	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes
115.341 (d)	Obtaining information from residents	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes
115.341 (e)	Obtaining information from residents	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	yes
115.342 (a)	Placement of residents	
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?	yes

	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?	yes
115.342 (b)	Placement of residents	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes
115.342 (c)	Placement of residents	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342 (d)	Placement of residents	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342 (e)	Placement of residents	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342	Placement of residents	

(f)		
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342 (g)	Placement of residents	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342 (h)	Placement of residents	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	na
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	na
115.342 (i)	Placement of residents	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes
115.351 (a)	Resident reporting	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.351 (b)	Resident reporting	

	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	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	yes

	the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.352 (g)	Exhaustion of administrative remedies	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	yes
115.353 (a)	Resident access to outside confidential support services and legal representation	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	Resident access to outside confidential support services and legal representation	

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

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

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

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

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

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

	is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	
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	yes

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

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

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

	harassment policies?	
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	yes

	take appropriate remedial measures, and consider whether to prohibit further contact with residents?	
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	yes

	for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	
	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	Access to emergency medical and mental health services	

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

	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (h)	Ongoing medical and mental health care for sexual abuse victims and abusers	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	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
	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	na
	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.)	yes
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.)	na