PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: August 18, 2017

Auditor Information			
Auditor name: Kyle D. Barrington			
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Telephone number: 979-696-6373			
Date of facility visit: April 3, 2017 to April 5, 2017			
Facility Information			
Facility name: Franklin House South			
Facility physical address: 1635 Ave. A., Beaumont, TX 77701			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 409-832-7564			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☒ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Ida Lane			
Number of staff assigned to the facility in the last 12 months: 21			
Designed facility capacity: 56			
Current population of facility: 56			
Facility security levels/inmate custody levels: Low			
Age range of the population: Over 17 years of age			
Name of PREA Compliance Manager: N/A		**Title:** N/A	
Email address: N/A		**Telephone number:** N/A	
Agency Information			
Name of agency: Land Manor, Inc.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 4655 Collier Street, Beaumont, TX 77706			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 409-838-3946			
Agency Chief Executive Officer			
Name: Dr. Michael Meyer		**Title:** Executive Director	
Email address: mmeyer@landmanor.org		**Telephone number:** 409-838-3946	
Agency-Wide PREA Coordinator			
Name: Ida Lane		**Title:** Quality Management Coordinator	
Email address: ilane@landmanor.org		**Telephone number:** 409-832-7564	

AUDIT FINDINGS

NARRATIVE

Land Manor Incorporated (Land Manor) requested a PREA Audit for the Franklin House South on February 8, 2017. The Franklin House South is in Beaumont, Texas. The pre-audit work began on February 8, 2017 and the onsite portion of the PREA Audit was conducted between April 3, 2017, and April 6, 2017. (NOTE: For the purposes of this PREA Report the term "Agency" always refers to Land Manor and the term "Facility" always refers to the Franklin House South).

The Data Audit Framework used by this auditor to assess the Agency's and Facility's compliance with the PREA Standards included the following: (1) Agency policies, (2) Facility procedures, (3) Interviews with 29 persons [Agency Head, PREA Coordinator, HR Manager, Investigator, Facility Director, Staff who perform Screening for Risk of Victimization and Abusiveness, Intake Staff, and Staff Responsible for Retaliation Monitoring, 10 security staff and 12 residents], (4) the Pre-Audit Questionnaire, (5) 23 client files, (6) 16 staff files and (7) associated attachments. Further, the Data Audit Framework relied on interviews of local area service providers [e.g., local area rape crisis center and local hospitals that would be used for forensic exams].

To complete this audit, this auditor used a triangulated audit methodology. First, all submitted and related documentation was reviewed. This included policies, procedures, organizational charts, forms, etc. After a thorough review of the documentation was completed, this auditor conducted interviews [semi-structured and unstructured] of staff, residents, and other stakeholders [local community-based organizations who provide victim advocacy services to residents, as well as, interviewing staff from the agencies responsible for investigating sexual abuse and sexual harassment allegations at the facility]. Once the interviews were completed, the auditor reviewed files, and reports. This allowed the auditor to determine if the agency and facility were complying with all related PREA standards.

An important part of the audit methodology was the site tour and review. On April 5, 2017, an auditor toured the Franklin House South. A review of the facility allowed the auditor to: (1) note obvious blind-spots; (2) observe the areas were residents typically shower, change clothes, and/or perform bodily functions; (3) note staff locations and movements; (4) record resident supervision levels; and (5) observe the types and abundance of communications between the facility and residents, via posters and notices.

To ensure that the audit process was fair and transparent, the auditor utilized a random selection process to identify security staff, residents, and files for review. At the beginning of the audit, the auditor asked for four lists. The lists were: (1) Current security staff sorted by last name; (2) Current residents sorted by last name; (3) Security staff who retired, resigned, or terminated within the past 12-months; and (4) Residents who discharged within the past 12-months. This auditor placed a number next to each name, on each list, starting with the number one (1) and moving upward in a sequential manner. Once all current security staff members were numbered, this auditor utilized a computerized random number generator to identify the security staff that were selected for interviews. This ensured that every security staff member had an equal chance of being selected for an interview. Careful attention was paid to ensure that security staff from all shifts were selected and that security staff assigned to different housing areas were selected. Once this was completed, this auditor repeated this process for each of the remaining lists. In all, this auditor interviewed 10 security staff, 12 residents, 16 files of security staff [100.0% of all staff], and 23 files of residents.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Franklin House South (also known as the Facility) is in an urban area of Beaumont, Texas and sits on approximately one acre. The facility is comprised of one large building and zero out buildings. The Facility is a single-story structure that contains the living quarters, group rooms, kitchen, offices, storage, laundry, and day room. All visitors pass through a secured hallway area at the main entrance. The Facility has two main hallways. The “Left” hallway contains three bunk rooms and the “Right” hallway contains four bunk rooms. One of the rooms in the right hallway is reserved for DSHS clients while the other rooms are reserved for TDCJ clients. In total, the facility can house up to 56 residents and all residents are former inmates from the Texas Department of Criminal Justice (TDCJ) and/or Department of State Health Services (DSHS). Over the course of the past 12-month period, it was determined that the average daily population was 56 and there were 53 residents on the first day of the onsite audit. All residents were identified as low-risk and all residents were female. The facility is rated to house residents over the age of 17. The facility employs 16 staff and for the purposes of the staff to resident ratio, all staff are considered “security” staff.

All criminal investigations would be handled by local law enforcement and via the TDCJ but the Agency does have three staff who have received PREA training related to administrative investigations of sexual abuse and sexual harassment. The facility only provides for supervision, feeding, substance abuse counseling, and transportation. All other services (e.g., medical, mental health, occupational, etc.) are provided outside of the facility. At the time of the onsite visit, the facility had two (2) volunteers and zero (0) contractors authorized to enter the Facility.

SUMMARY OF AUDIT FINDINGS

Prior to the onsite audit, which occurred on April 3, 2017 and ended on April 5, 2017, it was confirmed, via photographic email evidence provided by the PREA Coordinator, that the required PREA Audit notices were posted. That evidence confirmed that the notices were posted in various, conspicuous areas throughout each building that comprises the Facility.

Starting on February 25, 2017, this Auditor received an electronic package containing the completed Pre-Audit Questionnaire, agency policies and facility procedures via express shipping. Upon review of the information and data provided, it became clear that the Agency and the Facility had taken several steps toward meeting PREA compliance. A conference call with this Auditor and the Agency Head and the Agency's PREA Coordinator (PC) was conducted on March 30, 2017. This call confirmed that the Facility had made progress toward PREA compliance and confirmed that the Facility was ready for the onsite portion of the PREA Audit.

On the first day (April 3, 2017) of the onsite auditing, an introduction meeting was held at approximately 8:30 AM with the Agency Head, PREA Coordinator (PC), Interim Facility Director for Franklin House South, who was also the PREA Coordinator, Facility Director for Melton Center, and the Auditing team (comprised of the Lead Auditor, Kyle Barrington and a support staff, Joel Whitt). It was noted that there were 53 female residents onsite at the time of the audit. Following this meeting a tour of the entire Facility was conducted and this Auditor noted the layout of the physical grounds and the various structures. Additionally, this auditor observed posted notices about this PREA Audit, as well as, some posted notices regarding the rights of the residents to be free from sexual abuse. During this tour, it was noted that there were several "blind spots" but these areas had been noted by Facility staff. It was also noted that there were no security cameras in the Facility.

While participating in the tour, the Auditor observed residents being supervised by the Facility Staff (i.e., security staff). During the onsite, the auditing team formally interviewed 12 randomly selected residents, or 22.6% of the residential population. Residents reported being informed of the Facility's Zero-Tolerance Policy related to sexual abuse and sexual harassment and of their right to be free from sexual abuse and sexual harassment, as well as, their right to be free from retaliation for reporting sexual abuse and/or sexual harassment. All residents interviewed, 12 of 12, stated they did receive their PREA Education at time of intake. However, a review of client files found that one resident did not receive their PREA Information until the fifth day after intake and none of the DSHS clients, a total of four who were at the facility during the audit, had evidence they received PREA Information at intake. Staff confirmed that DSHS clients were not asked to sign a PREA Information confirmation form.

As part of the routine work assignment during the onsite portion of this PREA Audit, the auditing team interviewed a total of 10 security staff. All 10 were randomly selected security staff. The security staff interviewed represented staff from all shifts. In addition, the auditing team interviewed eight (8) specialized staff, to include, the Agency Head, PREA Coordinator, HR Manager, Investigator, Facility Director, Staff who perform Screening for Risk of Victimization and Abusiveness, Intake Staff, and Staff Responsible for Retaliation Monitoring. Overall, the staff interviews revealed that all staff were trained in the PREA Standards. Staff appeared confident about their roles as first responders and all had consistent answers on how a resident was to report sexual abuse and/or sexual harassment. However, a documented Coordinated Response Plan (CRP) could not be produced. Staff responsible for conducting intake risk assessments noted that they completed a risk screening but the screening was not objective and did not collect all the information required by PREA, particularly whether the resident is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming. In a review of 23 resident files, 5, or 21.7%, did not have evidence that PREA Information was provided during intake (defined as the first 24-hour period).

By the end of the onsite audit, it was found that the culture of PREA compliance was much more in evidence than the policies and procedures. Specifically, policies and procedures did not always reflect the practice. For example, some of the elements of the required definitions prescribed by PREA were not found in the policies and other required components of the PREA Standards could not be found in procedure. This resulted in many PREA Standards being identified as "non-compliant." However, the clear majority of these non-compliances should be easily remedied with minor updates to the Agency's policies followed by updates to the Facility's procedures, and, as needed, training of facility staff.

After the onsite portion of this PREA Audit, it was determined that the Facility "Exceeds Standard" on two (2) PREA Standards (115.253 & 115.264); "Meets Standard" on 15 PREA Standards, "Did Not Meet Standard" on 17 PREA Standards while 5 PREA

Standards (115.212; 115.218; 115.235; 115.252; and 115.266) were deemed “Not Applicable.”

During the 45-day report writing period the agency and facility provided additional information and materials to this auditor. Thus, as the end of the 45-day report writing period, this Auditor issued an Interim Report that determined that the Facility “Exceeds Standard” on two (2) PREA Standards (115.253 & 115.264); “Meets Standard” on 17 PREA Standards, “Did Not Meet Standard” on 15 PREA Standards while 5 PREA Standards (115.212; 115.218; 115.235; 115.252; and 115.266) were deemed “Not Applicable.” The Facility entered a Corrective Action Period on May 17, 2017.

Agency and facility staff worked diligently on the Corrective Action Plan (CAP). During the CAP period, the facility revised policy and procedure, trained staff, and underwent several ‘desk audits’ to help ensure the revised policies/procedures and training were institutionalized. At the end of the CAP period, this Auditor issued an Final Report that determined that the Facility “Exceeds Standard” on two (2) PREA Standards (115.253 & 115.264); “Meets Standard” on 32 PREA Standards, “Did Not Meet Standard” on 0 PREA Standards while 5 PREA Standards (115.212; 115.218; 115.235; 115.252; and 115.266) were deemed “Not Applicable.” The Facility exited the CAP period on August 13, 2017.

The following is a Standard-by-Standard summary of this Auditor’s findings, including the Corrective Action items, if any, in this PREA Audit.

Number of standards exceeded: 2

Number of standards met: 32

Number of standards not met: 0

Number of standards not applicable: 5

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.211: This standard has two components (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 and (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) Land Manor Policy number 448.601(Q) and Land Manor Policy Number 448.601 (QQ); 2) the Pre-Audit Questionnaire; 3) Land Manor's "Organizational Chart"; and 4) Interviews with staff.

OBSERVATIONS: The Agency's 448.601(Q) and 488.601(QQ) policies were reviewed and the following was noted: (1) the agency does have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract; (2 there are **no** definitions and no definitions of prohibited behaviors regarding sexual abuse and sexual harassment; (3) the agency does prescribe sanctions but only for staff-on-staff sexual harassment, but there are no sanctions noted for staff-on-resident abuse or resident-on-resident abuse; and (4) the policy does describe the agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents [Policy 448.601(QQ) serves this purpose]. The agency has employed an upper-level, agency-wide, but the PREA coordinator notes, in the pre-audit questionnaire, that they do **NOT** have sufficient time and authority to develop, implement, and oversee the agency's efforts to comply with the PREA standards in its facilities and this position is not listed on the Organizational Chart. However, interviews with the PREA Coordinator noted that this staff does feel they have sufficient time and authority to develop, implement, and oversee the agency's efforts to comply with the PREA standards in its facilities

DETERMINATION: It was determined that the Agency did not meet standard as the Agency did not have a policy that met the requirements of 115.211, the Facility did not have a procedure on how it will implement the Agency Zero Tolerance Policy, and the PREA Coordinator is not noted on the Organizational Chart. During the report writing phase, the facility revised the policies and procedures to meet some of the identified issues. However, staff still needed to be trained and an organizational chart was still needing to be updated.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The Facility will need to: (1) Train staff on the revised policies and/or procedures; (2) Submit to this Auditor evidence that staff attended and understood the training; and (3) Update and submit a revised Organizational Chart showing the position of the PREA Coordinator.

FINAL DETERMINATION: The Facility updated policies and procedures, provided training to appropriate staff, submitted evidence that the staff attended and understood this training, and updated the Organizational Chart. Thus, the Facility is deemed to meet this standard.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.212: This standard has three components: (a) A public agency that contracts for the confinement of its inmates 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; (b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards; and (c) Only in emergency circumstances in which all reasonable attempts to find a private agency or other entity in compliance with the PREA standards have failed, may the agency enter into a contract with an entity that fails to comply with these standards. In such a case, the public agency shall document its unsuccessful attempts to find an entity in compliance with the standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the Pre-Audit Questionnaire and 2) Interview(s) with the Agency and Facility staff responsible for contract monitoring.

OBSERVATIONS: Interviews with staff and residents supported the contention that the Agency has zero (0) contracts for confinement services.

DETERMINATION: Based on the observations noted above, including the staff interviews, it was determined that this PREA Standard is *not applicable* to this Agency.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.213: This standard has three components: (a) a staffing plan has been created; (b) deviations from the staffing plan are documented; and (c) the staffing plan is reviewed annually.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) Land Manor Policy number 448.903 & 448.601 QQ; 2) the Pre-Audit Questionnaire; and 3) Interviews with staff.

OBSERVATIONS: The Agency did not present a staffing plan but rather presented a policy (448.903) that states that "the facility shall, to the greatest extent possible, provide clients with access to full continuum of care…" This policy noted that the

staff to resident ratio, during non-sleeping hours, was 1 to 20 and during sleeping hours that ratio was 1 to 50. Interviews with staff noted that the staff to resident ratio during awake hours was 1 to 20 but other staff thought it was 1 to 16 during waking hours. All staff reported that the ratio was 1 to 50 at night. During interviews, staff noted that the staff to resident ratio kept residents safe as that was the ratio required by TDJC. When asked about documenting any deviations, it was reported that the facility does not document deviations and staff noted that deviations seldom occur. Agency policy 448.601QQ notes that "a review of facility staffing patterns will be conducted annually by the PREA Coordinator…and a copy will be provided to the TDCJ…" However, an annual review could not be located.

DETERMINATION: The Agency did not develop and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, the Agency did not take into consideration: (1) The physical layout of each facility; (2) The composition of the resident population; (3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (4) Any other relevant factors. Further, there is no mechanism for staff to report staffing plan deviations. In addition, there was no evidence that staffing plan, or even policy 448.903, is reviewed annually. Thus, it was determined that the Facility *does not* meet this Standard. During the report writing phase, the facility revised the staffing plan to meet some of the identified issues. However, a desk audit is needed to ensure the deviations from the staffing plan are being documented.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The Facility will need to: (1) *DESK AUDIT* to review all Staffing Plan deficiency notices.

FINAL DETERMINATION: The Facility completed a Desk Audit and was deemed to meet this standard.

Standard 115.215 Limits to cross-gender viewing and searches

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

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.

REQUIREMENTS: 115.215: This standard has six components: (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; (b) The agency shall not conduct cross-gender pat-down searches except in exigent circumstances nor shall Facilities restrict female inmates' access to regularly available programming or other outside opportunities in order to comply with this provision.; (c) The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches, and shall document all cross-gender pat-down searches of female inmates; (d) The facility shall implement policies and procedures that enable inmates 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 an inmate housing unit; (e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner; and (f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) Land Manor Policy number 448.601QQ; 2) the Pre-Audit Questionnaire; 3) Interviews with 10 security staff; and 4) Interviews with residents (specifically, 12 randomly selected residents).

OBSERVATIONS: Interviews with staff and residents confirmed that the Facility does not conduct cross-gender strip searches or cross-gender visual body cavity searches. Residents and staff noted that residents could 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. Further, interviews with residents confirmed that staff of the opposite gender always announce their presence when entering resident housing unit. Staff interviews noted that staff would not check a resident to determine their genital status and these findings were collaborated by interviews with residents. Security staff noted that they would never conduct a cross-gender pat search or a strip search. Female staff, who are responsible for all pat-down searches, stated they received training on how to conduct search of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs

DETERMINATION: Since all staff and resident interviews noted that residents are afforded the protections offered in this standard, it was determined that the Facility *does* meet this Standard.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.216: This standard has three components: (a) The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates 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; (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 inmates 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; and (c) The agency shall not rely on inmate interpreters, inmate readers, or other types of inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties under §115.64, or the investigation of the inmate's allegations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the Land Manor Policy number 448.601QQ; 2) the Pre-Audit Questionnaire; 3) Interviews with 10 security staff; and 4) Interviews with residents (specifically, 12 randomly selected residents).

OBSERVATIONS: Land Manor Policy 448.601QQ directly relates to this PREA Standard and interviews with 10 security staff noted that staff have not experienced a resident that meets this standard but all security staff noted that if it happens, the staff would notify their supervisor. Supervisors noted that they would provide a translator or translation services for any resident needing those services. However, the supervisors noted that TDCJ pre-screening would prevent a non-English speaking resident from entering the facility without advanced notice, thus the facility would be prepared with all necessary assistance.

DETERMINATION: As staff were able to identify how to access translation services that "can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary" and because the Agency noted that it 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 (per the Agency's pre-audit questionnaire) it was determined that the Facility *does* meet this Standard.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.217: This standard has eight components: (a) The agency shall not hire or promote anyone who may have contact with inmates, and shall not enlist the services of any contractor who may have contact with inmates, 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]; (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 inmates; (c) Before hiring new employees who may have contact with inmates, 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]; (d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates; (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 inmates or have in place a system for otherwise capturing such information for current employees; (f) The agency shall ask all applicants and employees who may have contact with inmates 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; (g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination; and (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility relied on the following: 1) Pre-Audit Questionnaire; 2) Interviews with agency staff during pre-audit conference calls; 3) Land Manor Policy 448.601QQ; 4) Review of 36 staff files; and 5) Onsite audit interviews with staff (specifically, Land Manor Human Resource staff).

OBSERVATIONS: In a review of 16 staff files, the following was identified: (1) Since 2016, the agency consistently asks employees about the questions related to 115.217(a)[1-3] prior to hiring; (2) The Agency was not considering any incidents of sexual harassment in determining whether to hire or promote anyone; (3) The agency was not making 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; (4) The Agency was not asking employees about misconduct described in 115.215(a) of this Standard during promotions or during employee evaluations; (5) The Agency policy does not impose upon employees a continuing affirmative duty to disclose any such misconduct; (6) The Agency does not state that

material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination (the only mention is related to criminal misconduct not civil adjudications). The Agency does not conduct background checks prior to first contact with residents in three out of 36 staff files reviewed and the Agency does not provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request form an institutional employer for whom such employee has applied to work. In an interview with HR staff it was noted that the Agency has in place a system to continual track criminal allegations. However, the HR staff could not identify the system, how the system works, how gets the notification of an arrest or allegation, what crimes are reported, how long this process takes, etc.

DETERMINATION: It was determined that the agency *does not* meet this Standard. However, during the report writing phase, the agency and facility worked to revise policies and procedures and to implement new forms. At the end of the report writing phase the agency and facility need to train staff on the revised policies and procedures and complete a desk audit.

CORRECTIVE ACTION PLAN (CAP): The facility entered the CAP period on May 17, 2017. The agency/facility shall: (1) Train effected staff (i.e., HR Staff, Supervisors, etc.) on the new policies and procedures, (2) Submit to this Auditor evidence that staff received and understood this training; and (3) *DESK AUDIT*: Once CAP items 1-9 are completed, this Auditor will wait 4-6 weeks and then will request documents related to hiring and promotion of staff and contractors.

FINAL DETERMINATION: The Facility updated policies and procedures, provided training to appropriate staff, submitted evidence that the staff attended and understood this training, and completed a Desk Audit. Thus, the Facility is deemed to meet this standard.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.218: This standard has two components: (a) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect inmates from sexual abuse; and (b) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect inmates from sexual abuse.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility relied on the following: 1) Pre-Audit Questionnaire and 2) Onsite audit interviews with staff (specifically, the Facility Director and Agency Head).

OBSERVATIONS: Based on staff and resident interviews it was determined that the Agency has not designed or acquired any new facility and is not, and has not since August 2012, made substantial expansion or modifications to existing facilities.

DETERMINATION: DETERMINATION: Based on the observations noted above, including the staff interviews, it was determined that this PREA Standard is *not applicable* to this Agency.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.221: This standard has eight components: (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; (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; (c) The agency shall offer all inmates who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. 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; (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 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; (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; (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; (g) The requirements of paragraphs (a) through (f) of this section shall also apply to: [(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in community confinement facilities; and (2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in community confinement facilities.] (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor 448.601QQ, (3) MOU with a local rape crisis center, and (4) Interviews with staff (specifically, the Facility Director and Agency investigator).

OBSERVATIONS: For investigations, the Agency investigator would handle all non-criminal sexual harassment allegations and for criminal sexual abuse allegations or criminal sexual harassment allegations the Agency would rely on local law enforcement. The agency has contacted the local area hospital and they do provide SANE nursing but does not guarantee one is always available. Interviews noted that staff were not sure what to do if a SANE nurse was unavailable and this issue was not addressed in the MOU. The Agency has contacted the local Rape Crisis Center. The Facility does have an investigator and the investigator has been trained. As for component (b), there is no documentation that local law enforcement and/or local hospitals whose staff may perform a forensic exam were asked to utilize 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.

DETERMINATION: It was initially determined that the Facility *does not* meet this Standard. However, during the report writing phase, the agency was able to; (1) Submit an email to local law enforcement asking them to utilize the appropriate protocol [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]; (2) Submit an email to the local hospital where a forensic examination may be performed asking them to utilize the appropriate protocol [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]; and (3) Submit these documents and/or correspondence to this auditor. Thus, by the time this Interim Report was issued it was determined that the Facility *does* meet this standard.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.222: This standard has five components: (a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment; (b) The agency shall have in place a policy 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. 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; (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; (d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations; (e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy 448.601QQ, (3) interviews with staff (specifically, the Facility Director and the Agency investigator), and (4) the search for the Facility website.

OBSERVATIONS: The Agency does have a policy related to investigations (Policy 448.601QQ) however that policy does not state that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment, the policy states investigations are only completed IF a resident wishes to file a report. The Agency does have a website but the Agency has not made their policies available. The Agency's investigative policy does not describe the responsibilities of both the Agency and the investigating entity (i.e., local law enforcement and/or DSHS, or TDCJ).

DETERMINATION: Since a separate entity is responsible for conducting criminal investigations and because the Agency's investigation policy does not describe the responsibilities of both the agency and the investigating entity, it is determined

that the Facility *does not* meet this Standard. However, during the report writing phase, the agency revised policies and procedures to address several issues identified during the onsite portion of the audit but the agency still needs to make these revisions available via the agency's website or other means of making it public.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The corrective action items include: (1) Ensure that this policy is posted on the Agency's website or otherwise made publicly available, and (2) Submit these documents to the Auditor.

FINAL DETERMINATION: The Facility ensured that the required policies/procedures were posted on the Agency website and submitted evidence of the same to this Auditor. Thus, the Facility is deemed to meet this standard.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.231: This standard has four components: (a) The agency shall train all employees who may have contact with inmates on 10 required topics; (b) Such training shall be tailored to the gender of the inmates at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male inmates to a facility that houses only female inmates, or vice versa; (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; and (d) The agency shall document, through employee signature or electronic verification, that employees understand the training they have received.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy 448.601QQ, (3) interviews with staff (specifically, the 10 randomly selected security staff), (4) Training forms, (5) Training curricula, and (6) 36 staff files.

OBSERVATIONS: Of the 10 random security staff interviewed, all 10, or 100.0%, noted that they did receive all the required PREA training. All staff interviews noted they felt they received training that was specific to the "gender of the residents at the Facility." In a review of staff files, it was apparent that staff received PREA training prior to the staffs' first contact with residents. However, none of the forms used by the Facility documented that staff "understood" the training as the training form was simply a certificate of attendance. In a review of the curriculum, if followed, should provide the necessary training for staff. Staff are provided with refresher training and information multiple times a year.

DETERMINATION: As the Agency cannot confirm that staff "understood" the training and because training was provided, in nine out of 20 files reviewed, after staff had first contact with residents, it was determined that the

Facility *does not* meet this Standard. However, during the report writing phase, the agency revised policies and procedures to address several issues identified during the onsite portion of the audit but the agency still needs to complete a desk audit.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the Corrective Action Period on May 17, 2017. The corrective action item included: (1) DESK AUDIT: Once all other CAP items for this Standard are completed, the Auditor will wait 8 to 12 weeks and request a list of all staff hired since the issuance of the Interim Report. Then the Auditor will request the training documents for these new staff to ensure that the staff acknowledged that they understood the training.

FINAL DETERMINATION: The Facility completed a Desk Audit and was deemed to meet this standard.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.232: This standard has three components: (a) The agency shall ensure that all volunteers and contractors who have contact with inmates have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures; (b) 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 inmates, but all volunteers and contractors who have contact with inmates shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents; and (c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy 448.602 and 448.601QQ, (3) interviews with staff (specifically, Program Director Staff), (4) Training forms, and (5) volunteer staff files.

OBSERVATIONS: The Facility provided evidence that they do not have contractors and this was supported via interviews with staff and residents. However, it was determined that a Pastor and their assistant did conduct some religious services with residents, thus, the facility does have volunteers and interviews noted that volunteers are not provided PREA training.

DETERMINATION: As volunteer training was not provided and/or not documented, the facility is determined to *not meet* standard. However, during the report writing phase, the agency revised policies and procedures to address several issues identified during the onsite portion of the audit but the agency still needs to edit the training form to ensure that volunteers and contractors sign-off that they understood the training and to complete a desk audit.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the Corrective Action Period on May 17, 2017. The corrective action items included: (1) Ensure that volunteers understand the training they have received; and (2)

DESK AUDIT: Once all other CAP items for this Standard are completed, the Auditor will request a list of new volunteers to ensure they receive the required PREA training prior to first contact with residents.

FINAL DETERMINATION: The Facility completed a Desk Audit and was deemed to meet this standard.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.233: This standard has five components: (a) During the intake process, residents shall receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents; (b) The agency shall provide refresher information whenever a resident is transferred to a different facility; (c) 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 residents who have limited reading skills; (d) The agency shall maintain documentation of resident participation in these education sessions; and (e) 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy 448.601QQ, (3) Interviews with residents (specifically, 12 randomly selected residents). (4) Training forms, (5) Training curricula, (6) A review of 23 resident files, and (7) Facility Tour.

OBSERVATIONS: Interviews with 12 residents and a review of 23 current residents' files revealed that not all the residents received PREA information during the intake process (particularly clients from the Department of State Health Services). During the tour of the facility this Auditor found that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. The material was presented in formats accessible to all residents at the facility (i.e., English and Spanish, with interpreter services, as needed). The agency does maintain documentation of resident participation in these education sessions.

DETERMINATION: Documentation did not exist on four of the clients at the facility that these residents received PREA Information upon intake (defined as within 24-hours of admission) it was determined that the Facility *does not* meet this Standard.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the Corrective Action Period on May 17, 2017. The corrective action items include: (1) Revise training to ensure that all residents receive PREA Information during the intake process; (2) Train effected staff on these revisions; (3) Submit evidence that staff attended and understood this training; and (4) DESK AUDIT: Once all other CAP items for this Standard are completed, the Auditor will

request a list of client intakes to ensure they receive the required PREA Information during intake.
FINAL DETERMINATION: The Facility updated policies and procedures to ensure that residents received education within permissible time periods, provided training to appropriate staff, submitted evidence that the staff attended and understood this training, and completed a Desk Audit. Thus, the Facility is deemed to meet this standard.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.234: This standard has four components: (a) In addition to the general training provided to all employees pursuant to § 115.231, 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; (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; (c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations; and (d) Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policies and Procedures, (3) interviews with Agency investigator, and (4) Training forms.

OBSERVATIONS: The Agency did provide evidence that the investigator had completed the required PREA training. Further, Agency policy noted that Land Manor does conduct sexual abuse investigations that are not criminal in nature.

DETERMINATION: As the Agency's investigator had received the required training related to investigations and the Agency policy stated that the Agency doesn't conduct criminal sexual abuse investigations, it was determined that the Facility *does* meet this Standard.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.235: This standard has four components: (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 victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment]; (b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations; (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; and (d) Medical and mental health care practitioners shall also receive the training mandated for employees under §115.231 or for contractors and volunteers under §115.232, depending upon the practitioner's status at the agency.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policies and Procedures, (3) interviews with staff (Facility Director and PREA Coordinator), and (4) Training forms.

OBSERVATIONS: Interviews with staff noted that the facility does not have medical or mental health staff at the facility. All mental health needs are provided offsite. Substance Abuse counselors, called LCDC's, per interviews with the Facility Administration, are not considered mental health staff.

DETERMINATION: It was determined that this standard is not applicable.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.241: This standard has five components: (a) All residents shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents; (b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility; (c) Such assessments shall be conducted using an objective screening instrument; (d) The intake screening shall consider, at a minimum, the nine (9) pieces of required information (see standard); (e) The intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive; (f) Within a set time period, not to exceed 30 days from the resident's arrival at the facility, the facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening; (g) A resident's risk level shall be reassessed when warranted due to a

referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness; (h) Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section; (i) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents..

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, (3) interviews with staff (specifically, the counselors), (4) the PREA Risk Screening Form, and (5) A review of 11 resident files.

OBSERVATIONS: The Facility conducts risk screening using a tool called the Sexual Abuse Questionnaire (SAQ). This tool is not an objective risk assessment tool. The counselors do utilize resident intake responses to a variety of questions, including questions related to past victimizations and abusiveness. The questionnaire does inquire about physical build and whether the resident/client is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming. The staff uses the Sexual Abuse Questionnaire, a personal interview, and any other available relevant records to assess each residents' risk for self-harm but not for sexual aggressive behavior and vulnerability to sexual victimization. In a review of 23 files, 18 (78.3%), of the residents did receive this SAQ screening within 72-hours. Staff interviewed noted that they do conduct reassessments every 30-days but reassessments could not be verified on 21.7% of the files reviewed.

DETERMINATION: It was determined, based on the observations noted above, that the Facility *does not* meet this Standard. However, during the report writing phase, the agency revised policies and procedures to address several issues identified during the onsite portion of the audit but the agency still needs to train staff and to complete a desk audit.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. CAP items include: (1) Submit evidence that staff responsible for risk assessment attended and understood the training; and (2) DESK AUDIT: Once CAP item 1 is completed for this corrective action plan, this Auditor will wait at least 4-8 weeks and request copies of the form to ensure that the forms are being utilized.

FINAL DETERMINATION: The Facility provided training to appropriate staff, submitted evidence that the staff attended and understood this training and completed a Desk Audit. Thus, the Facility is deemed to meet this standard

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.242: This standard has six components: (a) The agency shall use information from the risk screening required by § 115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually

abusive; (b) The agency shall make individualized determinations about how to ensure the safety of each resident; (c) In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems; (d) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration; (e) Transgender and intersex residents shall be given the opportunity to shower separately from other residents; (f) The agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, (3) interviews with residents (specifically, 10 randomly selected residents), and (4) Interviews with staff (specifically the 10 randomly selected security staff).

OBSERVATIONS: All 10 randomly selected staff interviewed supported the contention that the Facility "never" places a resident in isolation for their own protection against sexual victimization. Further, interviews documented that the risk assessments are not used to make placement and programmatic decisions related to sexual abusiveness or sexual victimization. One staff noted that once the SAQ is completed they "file it and don't look at it again until an audit." Staff interviews noted that they have not had any transgender or intersex residents at the facility in the past 24-months. Staff also noted that they would not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely based on such identification or status.

DETERMINATION: As the current risk assessment tool is not objective and is filed away immediately upon completion, the facility cannot use it to make informed decisions, thus it was determined that the Facility *does not* meet this Standard.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The CAP items are identified: (1) Once a tool that is compliant with 115.241 is utilized ensure that it is used to make informed decision per this standard; (2) Train staff to utilize this tool, (3) Submit evidence to this auditor that the staff responsible for placement decisions have attended and understood the training; and (4) DESK AUDIT: Once all CAP items are completed for this corrective action plan, this Auditor will conduct a conference call with counselors to determine how placement decisions are made.

FINAL DETERMINATION: The Facility identified an appropriate objective screening tool, trained staff on this tool, provided evidence that staff attended and understood this training, and completed a Desk Audit. Thus, the Facility is deemed to meet this standard.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.251: This standard has four components: (a) The agency shall provide multiple internal ways for inmates to privately report sexual abuse and sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents; (b) The agency shall also inform residents of at least one way 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; (c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports; and (d) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of inmates.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, (3) Interviews with residents (specifically, 12 randomly selected residents), (4) Interviews with staff, (5) Access to the phone system to make a call to an outside agency; and (6) Review of allegations and investigations of those allegations.

OBSERVATIONS: Twelve of the 12 residents, 100.0%, could identify multiple internal ways for a resident to report privately to Facility officials about sexual abuse, sexual harassment, retaliation, and staff neglect or violation of responsibilities that may have contributed to any such incidents. All the interviewed residents noted that they would tell a staff member and all residents noted that they can privately report. All the residents could identify a public or private entity or office that is not part of the agency that can receive and immediately forward residents reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. All staff interviewed noted that they must report all verbal reports, anonymous reports, written reports, and reports from third parties regarding allegations of sexual abuse and sexual harassment. All security staff interviewed (10 out of 10) noted that they had multiple methods to privately report sexual abuse and sexual harassment of residents. Finally, there were no reported allegations of sexual abuse or sexual harassment to review.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.252: This standard has seven components: (a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse; (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; (b)(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; (b)(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; (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]; (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; (d)(2) Computation of the 90-day time period shall not include time consumed by inmates in preparing any administrative appeal; (d)(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; (d)(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; (e)(1) Third parties, including fellow inmates, staff members, family members, attorneys, and outside advocates, shall be permitted to assist inmates in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of inmates; (e)(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; (e)(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision; (e)(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; (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; (f)(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; and (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Interviews with staff, and (3) Interviews with residents.

OBSERVATIONS: The agency does have administrative procedures to address inmate grievances regarding sexual abuse. However, the grievance procedure does not preclude the inmates from, at any time, proceeding to court to directly seek judicial redress for any allegation of sexual abuse without having to file a grievance at the Agency.

DETERMINATION: It was determined that this standard is not applicable.

Standard 115.253 Resident access to outside confidential support services

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.253: This standard has three components: (a) The facility shall provide inmates 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 inmates and these organizations and agencies, in as confidential a manner as possible; (b) The facility shall inform inmates, 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; and (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 inmates with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter such agreements.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures., (3) Interviews with residents (specifically, 12 randomly selected residents), (4) Interviews with staff (specifically the 10 randomly selected security staff), and (5) Interviews with the PREA Coordinator.

OBSERVATIONS: Evidence was found that the Facility provided contact phone numbers and addresses to the local area Rape Crisis Center. A phone interview with the Rape Crisis Center noted that this Facility would provide services to residents from the Facility, if requested. All the staff and all the residents knew about the requirement of providing residents with access to outside victim advocates and as noted, there was evidence that the Facility made accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. Residents and staff noted that the phone calls are not monitored. The agency did provide documentation showing that the Agency did enter an MOU with the local Rape Crisis Center.

DETERMINATION: It was determined that as the Facility has a signed MOU with the local rape crisis center, that the Facility makes available phone access to outside support services, via the rape crisis center, and because the Facility has implemented a program of having rape crisis center staff come to the facility to provide information to residents and to conduct confidential support services, with consent of the resident, the Facility *exceeds* the requirements of this Standard.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.254: This standard has one component: (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, (3) Interviews with residents (specifically, 12 randomly selected residents), (4) Interviews with staff (specifically the 10 randomly selected security staff), and (5) Facility tour where evidence of postings related to this Standard were found.

OBSERVATIONS: This Facility has not identified multiple means of receiving third-party reports and information about third-party reporting is not made available on the Agency's website at http://www.landmanor.org/ourfacilities.html.

DETERMINATION: As the Agency has not established a method to receive third-party reports of sexual abuse and sexual harassment and has not distributed this information, it was determined that the Agency *does not* meet this Standard.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The following CAP items are identified: (1) Identify how the agency will 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, and (2) Submit this information to this auditor.

FINAL DETERMINATION: The Facility established a method to receive third-party reports of sexual abuse and sexual harassment, distributed, publicly, information on how to report sexual abuse and sexual harassment on behalf of a resident, and submit this information to this auditor. Thus, the Agency is deemed to meet this standard.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.261: This standard has five components: (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 inmates or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation; (b) 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; (c) Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services; (d) If the alleged victim is under the age of 18 or

considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws; and (e) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, and (3) Interviews with staff (specifically the 10 randomly selected security staff).

OBSERVATIONS: Staff interviews supported the contention that the Facility is following this PREA Standard. All staff noted they understood that they were to report all sexual abuse and sexual harassment allegations.

DETERMINATION: As all staff noted that they would report all allegations of sexual abuse or sexual harassment it was determined that the Facility *does* meet this Standard.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.262: This standard has one component: (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, (3) Interviews with residents (specifically, 12 randomly selected residents), and (4) Interviews with staff (specifically the 10 randomly selected security staff).

OBSERVATIONS: Land Manor Policy 448.601QQ specifically addresses this requirement. During interviews of 12 randomly selected staff, all 12-staff noted that they would act immediately to protect a resident who was subject to a substantial risk of imminent sexual abuse by moving the resident or placing them in line of sight while contacting a supervisor. All residents' who were interviewed noted that they felt staff would take immediate action to protect them.

DETERMINATION: As 100.0% of the interviewed staff noted that they would take immediate action to protect the resident, it was determined that the Facility *does* meet this Standard.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.263: This standard has four components: (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; (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation; (c) The agency shall document that it has provided such notification; and (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policies and Procedures, (3) Interviews with staff (specifically the 10 randomly selected security staff), (4) Interviews with the Facility Head and (5) Interviews with the Agency Head.

OBSERVATIONS: Land Manor Policy 448.601QQ mentions this requirement and the Facility Head noted that they would ensure that the policy was followed.

DETERMINATION: As interviews noted that the facility has never received an allegation related to this Standard and that these same interviews noted they would report the allegation in accordance to this Standard it was determined that the facility *does* meet this Standard.

Standard 115.264 Staff first responder duties

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.264: This standard has two components: (a) Upon learning of an allegation that an inmate 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; and (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]; and (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures., (3) Interviews with staff (specifically the 10 randomly selected security staff), and (4) Interviews with the Facility Head.

OBSERVATIONS: All 11 of the 10 randomly selected security staff understood their role as first responders and the staff had a first responder card attached to their lanyard with their identification badge.

DETERMINATION: It was determined that the Facility *exceeds* this Standard as all staff knew what to do in case they had to act as a first responder and because the staff have response cards attached to their lanyards.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.265: This standard has one component: (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, (3) Interviews with staff (specifically the 10 randomly selected security staff), (4) Interviews with the Facility Head and (5) Interviews with the Agency Investigator.

OBSERVATIONS: The *Coordinated Response Plan* is not written. Interviews with staff confirmed that they were unaware of what their role was or even if a Coordinated Response Plan existed.

DETERMINATION: It was determined that the Facility *does not* meet this Standard. However, during the report writing phase, the agency and facility created a Coordinated Response Plan but the agency still needs to provide staff training.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. CAP items include: (1) Train staff in the revised plan; and (2) Submit to this Auditor evidence that staff attended and understood the training related to the CRP.

FINAL DETERMINATION: The Facility trained staff on the revised plan and submitted to this Auditor evidence that staff attended and understood the training related to the CRP. Thus, the Agency is deemed to meet this standard.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.266: This standard has two components: (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 inmates pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted, and (b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern: [(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.272 and 115.276; or (2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.]

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire and (2) Interview with the Agency Head.

OBSERVATIONS: An interview with the Land Manor Agency Head noted that the agency *does not* have a collective bargaining agreement.

DETERMINATION: It was determined that this standard is not applicable to this Agency.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.267: This standard has six components: (a) The agency shall establish a policy to protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff and shall designate which staff members or departments are charged with monitoring retaliation; (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 inmates or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations; (c) For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of inmates or staff who reported the sexual abuse and of inmates who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by inmates 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; (d) In the case of inmates, such monitoring shall also include periodic status checks; (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; and (f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures., (3) Interviews with staff (specifically the 10 randomly selected security staff), (4) Interviews with residents (specifically, 12 randomly selected residents); and (5) Interviews with specialized staff.

OBSERVATIONS: Land Manor Policy 448.601QQ addresses this standard however it only covers sexual abuse and does not mention sexual harassment. Interviews with staff revealed that staff do not understand who is designed as a 'retaliation monitor.' This Auditor received information from many different staff and each staff identified another staff member as the person responsible for retaliation monitoring. Interviews with staff who understood some of the retaliation monitoring process did not know how long retaliation monitoring lasted.

DETERMINATION: It was determined that the Facility *does not* meet this Standard. However, during the report writing phase, the agency revised policies and procedures to address several issues identified during the onsite portion of the audit but the agency still needs to train effected staff and to complete a desk audit.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The three corrective action items include: (1) Provide training to all staff who are, or might be, responsible for retaliation monitoring to ensure that they are aware of the requirements for retaliation monitoring; (2) Submit to this auditor signed documents noting that staff received and understood the revisions to this policy; and (3) ***DESK AUDIT***: After CAP items 1 and 3, referenced above, are completed the Auditor will wait 6-8 weeks and then request a list of all residents and/or staff provided retaliation monitoring. From this list, the Auditor will request documentation supporting that retaliation monitoring is being implemented per policy and procedure.

FINAL DETERMINATION: The Facility provided training to all staff who are, or might be, responsible for retaliation monitoring to ensure that they are aware of the requirements for retaliation monitoring, submitted to this auditor signed documents noting that staff received and understood the revisions to this policy and completed a *DESK AUDIT*. Thus, the Agency was deemed to meet this standard.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.271: This standard has 12 components: (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; (b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.234; (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; (d) 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; (e) 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; (f) 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]; (g) 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; (h) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution; (i) The agency shall retain all written reports referenced in paragraphs (f) and (g) 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; (j) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation; (k) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements; and (l) 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures., (3) Interviews with staff (specifically the 10 randomly selected security staff), and (4) Interviews with Agency Investigators.

OBSERVATIONS: It was determined, via interviews, which Agency and Facility staff may be asked to conduct non-criminal sexual abuse and/or sexual harassment investigations. Further, the Agency investigators noted that they would not allow 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. For administrative investigations, it was found that investigators would include in their reports an effort to determine whether staff actions or failures to act contributed to the abuse; and documentation in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. However, there have been no allegations and thus no reports could be reviewed.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.272: This standard has one component: (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, and (3) Interviews with investigators.

OBSERVATIONS: During interviews with investigative staff it was determined that investigators do not know what standard of evidence is to be used for investigations.

DETERMINATION: It was determined that the Facility *does not* meet this Standard. However, during the report writing phase, the agency revised policies and procedures to address several issues identified during the onsite portion of the audit but the agency still needs to train effected staff.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The three corrective action items include: (1) Ensure that Agency investigators are trained on the standards of evidence; and (2) Submit to this auditor signed documents noting that staff received and understood this training.

FINAL DETERMINATION: The Facility ensured that Agency investigators are trained on the standards of evidence and submitted to this auditor signed documents noting that staff received and understood this training. Thus, the Facility is deemed to meet this standard.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.273: This standard has six components: (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; (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; (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]; (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]; (e) All such notifications or attempted notifications shall be documented; and (f) An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedure. (3) Interviews with PREA Coordinator, and (4) Interview with the Investigator.

OBSERVATIONS: Policy 448.601QQ. addresses this Standard. Interviews with staff confirmed that they would follow the policies and procedures outlined in Land Manor Policies and Procedures and noted that they would informed every resident who alleges sexual abuse and/or sexual harassment about the findings of those investigations.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.276: This standard has four components: (a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies; (b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse; (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; (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedure., (3) Interviews with PREA Coordinator, (4) Interview with Investigator, and (5) Interview with Facility Director.

OBSERVATIONS: Land Manor Policy 448.601QQ, addresses this Standard. Interviews supported the contention that staff would be disciplined for violating the sexual abuse and/or sexual harassment policies. Further, Land Manor Policy and Procedure states that termination is the presumptive disciplinary sanction.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.277 Corrective action for contractors and volunteers

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

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.

REQUIREMENTS: 115.277: This standard has two components: (a) Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with inmates and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies; and (b) The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with inmates, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedure., (3) Interviews with PREA Coordinator, (4) Interview with Investigator, and (5) Interview with Facility Director.

OBSERVATIONS: Land Manor Policy and Procedures complies with this Standard and interviews with staff support the contention that these policies and procedures would be followed.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.278 Disciplinary sanctions for residents

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

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.

REQUIREMENTS: 115.278: This standard has seven components: (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; (b) Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other inmates with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Inmates in isolation shall receive daily visits from a medical or mental health care clinician. Inmates shall also have access to other programs and work opportunities to the extent possible; (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; (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; (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; (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; and (g) An agency may, in its discretion, prohibit all sexual activity between inmates and may discipline inmates for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedure., (3) Interviews with PREA Coordinator, (4) Interview with Investigator, and (5) Interview with Facility Director.

OBSERVATIONS: It was noted in Land Manor Policy and Procedures that residents will be disciplined per the appropriate disciplinary code or code of conduct. Based on the pre-onsite visit conference calls with the Agency Head and via the Pre-Audit Questionnaire, and via interviews during the onsite, the Facility would not use isolation as the sole sanction for resident-on-resident sexual abuse. Interviews with staff noted that they 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. In addition, interviews confirmed that the facility does not offer therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, thus 115.278(d) is not applicable.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.282: This standard has four components: (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; (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 § 115.262 and shall immediately notify the appropriate medical and mental health practitioners; (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; and (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Interviews with PREA Coordinator, (3) Land Manor Policy and Procedures, (4) Interviews with Counselors, and (5) Interview with Facility Director.

OBSERVATIONS: The onsite visit interviews noted that resident victims of sexual abuse would be provided with unimpeded access to emergency medical treatment and crisis intervention services. Further, interviews acknowledged that 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. These findings were supported by Agency Policy 448.601QQ.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.283: This standard has eight components: (a) The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all inmates who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility; (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; (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care; (d) Resident victims of sexually abusive vaginal penetration while incarcerated 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; (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate; (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; and (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Interviews with PREA Coordinator, (3) Land Manor Policy and Procedure., (4) Interviews with Counselors, and (4) Interview with Facility Director.

OBSERVATIONS: Interviews confirmed that the Facility does attempt to ascertain information about a history of sexual abuse (see 115.241) and follow-up services with the local rape crisis center for services, evaluations or treatment are provided. The agency's policy 448.601QQ addresses this Standard. In a review of 11 of 11 resident files, it was found that in the two cases that residents reported past sexual abuse and requested follow-up services, those services were provided within 14-days.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.286: This standard has five components: (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; (b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation; (c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners; (d) The review team shall: [(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager]; (e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Interviews with PREA Coordinator, (3) Agency Policy and Procedure, (4) Interviews with Counselors, and (5) Interview with Facility Director.

OBSERVATIONS: Interviews with staff indicated that the Facility was aware that a Sexual Abuse Incident Review

was needed after every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded and that this review should be done within 30-days of the conclusion of the investigation. However, no investigations have been conducted.

DETERMINATION: It was determined that the Facility *does* meet this Standard.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.287: This standard has six components: (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; (b) The agency shall aggregate the incident-based sexual abuse data at least annually; (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 (SSV) conducted by the Department of Justice; (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; (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its inmates; and (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedure, (3) Interviews with PREA Coordinator, (4) Interviews with staff, and (5) Interview with Facility Director.

OBSERVATIONS: The Facility could not produce a Standardized instrument that could collect accurate uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. An interview with the PREA Coordinator and Facility Director, indicated that Land Manor does not maintain, does not review, and does not collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

DETERMINATION: It was determined that the Facility *does not* meet this Standard. However, during the report writing phase, the agency revised policies and procedures to address several issues identified during the onsite portion of the audit and could identify a standardized instrument. Thus, by the issuance of this Interim Report, the facility had meet this standard.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.288: This standard has four components: (a) The agency shall review data collected and aggregated pursuant to § 115.287 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]; (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; (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; and (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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedures, (3) Interviews with PREA Coordinator, (4) Interviews with staff, and (5) Interview with Facility Director.

OBSERVATIONS: No data or annual report was made available to this Auditor.

DETERMINATION: It was determined that the Facility *does not* meet this Standard. However, during the report writing phase, the agency collected and reviewed aggregated data but the agency needs to create an annual report that meets standard.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The four corrective action items include: (1) Ensure that such a report includes 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; (2) Ensure the agency's report is 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; (3) Ensure that the agency redacts 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, and (4) Submit a copy of this report to the Auditor.

FINAL DETERMINATION: The Agency ensured that such a report includes a comparison of the current year's data and corrective actions with those from prior years and provided an assessment of the agency's progress in addressing sexual abuse; the Agency ensured the report is 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; ensured that the agency redacts 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, and submitted a copy of this report to the Auditor. Thus, the Agency is deemed to meet this standard.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

REQUIREMENTS: 115.289: This standard has four components: (a) The agency shall ensure that data collected pursuant to § 115.287 are securely retained; (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; (c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers; and (d) The agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Land Manor Policy and Procedure, (3) Interviews with PREA Coordinator, (4) Interviews with staff, and (5) Interview with Facility Director.

OBSERVATIONS: No data or annual report was made available to this Auditor.

DETERMINATION: It was determined that the Facility *does not* meet this Standard. However, during the report writing phase, the agency revised policies and procedures to address several issues identified during the onsite portion of the audit but the agency still needs to produce an annual report so this Auditor can verify that personal identifiers are removed and that the report is readily available.

CORRECTIVE ACTION PLAN (CAP): The Facility entered the CAP period on May 17, 2017. The five corrective action items include: (1) Once Standard 115.288 is considered to meet Standard the agency shall ensure that aggregated sexual abuse data does not contain personal identifiers; (2) Once Standard 115.288 is considered to meet Standard the agency shall ensure that aggregated sexual abuse data is made readily available to the public at least annually through its website or, if it does not have one, through other means (posting at the Facility, etc.), and (3) Submit to this Auditor evidence of where data related to this Standard are retained and how the data are retained.

FINAL DETERMINATION: The Agency completed all CAP items and was deemed to meet this standard.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Kyle D. Barrington [electronic signature] August 18, 2017

Auditor Signature Date