PREA Facility Audit Report: Final

Name of Facility: Grateful Life Center
Facility Type: Community Confinement
Date Interim Report Submitted: 01/01/2023
Date Final Report Submitted: 05/13/2023

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	■
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	■
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	■
Auditor Full Name as Signed: Ramona Wheeler	**Date of Signature:** 05/13/2023

AUDITOR INFORMATION	
Auditor name:	Wheeler, Ramona
Email:	ramona.wheeler@alvis180.org
Start Date of On-Site Audit:	08/15/2022
End Date of On-Site Audit:	08/17/2022

FACILITY INFORMATION	
Facility name:	Grateful Life Center
Facility physical address:	305 Pleasure Isle Drive, Erlanger , Kentucky - 41017
Facility mailing address:	

Primary Contact	
Name:	Brandon Suhr
Email Address:	Bsuhr@transitionsky.org
Telephone Number:	8593594500

Facility Director	
Name:	Brandon Suhr
Email Address:	Bsuhr@transitionsky.org
Telephone Number:	8593594500

Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	

Facility Characteristics	
Designed facility capacity:	100
Current population of facility:	85
Average daily population for the past 12 months:	90
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	18 and up
Facility security levels/resident custody levels:	Community/Recovery Center
Number of staff currently employed at the	9

facility who may have contact with residents:	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Transitions, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	1650 Russell Street , Covington , Kentucky - 41011
Mailing Address:	
Telephone number:	

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

Agency-Wide PREA Coordinator Information			
Name:	Brandon Suhr	**Email Address:**	bsuhr@transitionsky.org

Facility AUDIT FINDINGS

Summary of Audit Findings

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

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

Number of standards exceeded:	
0	
Number of standards met:	
41	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2022-08-15
2. End date of the onsite portion of the audit:	2022-08-17

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	PREA Hotline @ 1-833-362-7732 - reached the KY Justice Cabinet; it was explained that if a GLC/DOC client called they would submit the report to the KY DOC, but they do not investigate reports. Ion Center for Violence Prevention (formerly Women's Crisis Center) @ 1-800-928-3335; the number is a 24/7 confidential crisis hotline. The responder explained to the auditor that they would encourage a resident to seek medical attention, if needed; they provide emotional support, and will stay with the client during SAFE/SANE exam; it was explained that they provide hospital runs between 7pm and 7:59am. An interventionist would speak with the client, provide emotional support, refer to other resources for possible shelter placement, assist with SAFE exam at the hospital, as an option; clients who go to St. Elizabeth for sexual abuse would be referred to the Ion Center, who would ask if the client wants to contact law enforcement, and will wait in the waiting room during SAFE exam; if refused, they will wait until the patient is discharged.

AUDITED FACILITY INFORMATION	
14. Designated facility capacity:	110
15. Average daily population for the past 12 months:	100
16. Number of inmate/resident/detainee housing units:	41
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	○ Yes ◉ No ○ Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)
Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
36. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	100
38. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	1
39. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	1

40. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	1
41. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
42. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
43. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	2
44. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
45. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
46. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	0
47. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0

48. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	On 8/15/2022, at approximately 8:19am, the auditor arrived at the Grateful Life Center (GLC), located in Erlanger, Kentucky. The front entrance is not locked; a Peer Mentor stationed at the front door at a desk asked the auditor (and assistant) to sign-in. The auditor was expected, so not required to sign-in, per instructions from the PREA coordinator, who was waiting in the front lobby. The Lobby is set up similar to a home living room, with two sofas, a loveseat and lazy boy chair. Trophies are displayed from intramural softball tournaments in past years, as well as certificates of appreciation from various community ministries. An elevator is located in the lobby that goes to floors 2, 3, and are only used by handicapped residents or staff. Resident visitation is not active due to the Covid-19 pandemic. The auditor observed a PREA audit notice posted in the main lobby in bright yellow paper. The auditor asked residents informally how long the posting had been there. Responses ranged from "a while", to "weeks", to "I don't know". The auditor observed a variety of resident forms, and information posted on the wall at the cafeteria entrance. Forms contained housing information, facility universal rules and procedures, resident rights, facility cleaning schedule, privileges by program phase, and PREA posters with hotline numbers. An ornamental tree lists deceased persons, contributing organizations to GLC. The auditor spoke informally to Peer Mentors about their role in the facility. One person stated they have been where other residents are, and keeping them within program rules, respecting boundaries is well received by those actively in the GLC program. The auditor asked a random resident what he thought about being monitored by those who have been in the GLC program, and he responded that he hoped to be able to get to that level, that the Peer Monitors are daily examples that they can get to "...the other side" [of their addiction issues]. The auditor observed that resident movement

	through the facility is intentional, and with purpose: residents with free time are in their room, classroom, or lounge. Others are reminded by staff of upcoming activities. During random resident interviews, residents expressed appreciation for the GLC program, and how they would likely be on the street, or worse, without a program like it. Residents stated that PREA violations are not a real concern, as recovery is everyone's primary focus. Residents who identified as gay, or bi-sexual stated they felt safe, and respected by GLC staff and residents. They stated that if anyone made an insulting, or disrespectful comment, they would be met with violations. Residents stated they value earned privileges, and work hard not to lose them.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
49. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	8
50. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
51. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0

52. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	The Grateful Life Center (GLC) is a recovery housing facility. PREA compliance is required due to receiving referrals from the Kentucky Department of Corrections (KYDOC). There is at least one person on staff 24 hrs. per day, seven days per week, along with Peer Mentors, who serve as 'security', and are posted at the front entrance, and near elevators on the 2nd, and 3rd floors. The facility has 10 regular employees onsite. The Chief Executive Officer (CEO), and Human Resources director have offsite offices, but were present for specialized interviews during the onsite audit phase. Four of 10 staff serve as case managers. One case manager is a former GLC resident (13 mos.), and Peer Mentor, who was hired as a regular employee in 2021. Other positions include: • PREA Coordinator/Director • Facility Director • SOS/MT Supervisor • Phase 1 & 2 Supervisor • Case Manager/Intake Coordinator • Administrative Assistant Of 10 employees, only two who work directly with residents have been employed at GLC five or more years (not including the CEO, and HR director, who have offsite offices). Supervisors often carry a caseload, and serve in other PREA-related capacities (i.e., Investigator, Risk Screening, retaliation monitoring). During his interview, the CEO stated that GLC staff understand that relapse is part of the recovery (from substance use) process, and that some staff have had similar experiences. This is what makes GLC's program unique, in that residents may return to a Transitions program, and work their way back to the GLC. The fact that residents have been justice-involved is not the focus, as most offenses are related to substance use. The goal to lead a sober, productive lifestyle. Returning residents may recognize staff who have previously been in the residential program, and served as a Peer Mentor. They are a

	source of inspiration and encouragement for current residents, and champion resident success through each program phase. Staff are well trained and caring, but not licensed: clients are referred across the street for medical services and counseling, if/when needed. Most; mostly master-level counselors.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	16
54. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☐ Age ☐ Race ☐ Ethnicity (e.g., Hispanic, Non-Hispanic) ☐ Length of time in the facility ☐ Housing assignment ☐ Gender ☐ Other ☒ None
If "None," explain:	The auditor selected random residents by numerically selecting every 5th name on the resident roster. If a resident was not present, the next name on the roster was selected, until 16 interviews were completed. Personal identifiers were not a factor, other than those required under the "targeted" population definition for PREA audits. No selected resident refused to be interviewed.

55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	The GLC has one location, so there were no geographical differences to consider for this audit.
56. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	(●) Yes ( ) No
57. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	The GLC is an adult male facility; therefore, no female residents were interviewed. The predominance of the population are White males, thus over-represented among the 16 residents selected.
Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	4
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/ resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/ residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
60. Enter the total number of interviews conducted with inmates/residents/ detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	1

61. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	1
62. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	1
63. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The PAQ indicated that GLC did not house residents from the following targeted categories: • Deaf/hard-of-hearing Of 16 resident interviews, no resident identified as having a hearing impairment, or were observed with a hearing aid/device.
64. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The PAQ indicated that GLC did not house residents from the following targeted categories: • Limited English Proficient Of 16 resident interviews, and during informal conversations, no resident(s) was identified as having English as a second language, or with any need for an interpreter, or translator. During the onsite facility review, the auditor observed multiple posters with information in English and Spanish, which provide residents multiple ways to report allegations, both internally and externally. During interviews with the GLC CEO, as well as the PREA coordinator, both stated no resident has requested assistance, or information in a non-English language.
65. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	2
66. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The PAQ indicated that GLC did not house residents from the following targeted categories: • Transgender or intersex Of 16 resident interviews, and during informal conversations, no resident(s) was identified as a trans-male, or intersex. The auditor asked staff who conduct resident intake screenings if she has encountered a resident who identified as trans-male, or intersex, and the response was 'no'. Resident screening documentation did not indicate that any GLC resident, during the onsite audit, identifies as transgender, or intersex.
67. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The PAQ indicated that GLC received one allegation in the past 12 months of sexual abuse. The residents identified in the allegation were not at the GLC facility at the time of the onsite audit. The PREA coordinator provided investigative documentation from the KYDOC, which concluded the matter as Unsubstantiated. The PREA coordinator provided in the PAQ documentation of the GLC's efforts to reach the alleged victim, with no success.
68. Enter the total number of interviews conducted with inmates/residents/detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The PAQ indicated that, in the past 12 months, no GLC resident reported prior sexual abuse during incarceration. The auditor interviewed 16 residents during the onsite audit phase. No resident disclosed prior sexual abuse, or claimed knowledge of such. Resident PREA screening documentation was reviewed as supportive documentation. No intake screening documents indicated a resident disclosed prior sexual abuse.

69. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The PAQ indicated that no GLC residents were, or have been placed in segregated housing for risk of sexual victimization. During the onsite audit the PREA auditor identified Room 132, known as the Risk/Re-focus room, where alleged victim(s) of sexual abuse may be placed. The room, with four beds, are primarily used for residents who completed their GLC program, but have relapsed; this space offers an option other than being on the street. During the onsite facility review, the auditor observed that Room 132 was unoccupied.

70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	During the onsite audit phase, the auditor asked the PREA coordinator to identify any known residents whom may meet the definition of each Targeted category. All identified residents in any Targeted category were interviewed. Residents were cooperative, and did not communicated barriers to reporting a PREA allegation, or having access to information for reporting a PREA allegation, internally, or externally, should there be a need to know. During random and targeted resident interviews residents widely shared that routine resident education is conducted by the case manager regarding ways to report allegations, and access to external resources. The auditor observed posters in the facility in English and Spanish, which provide information on ways to report allegations, internally, and externally.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
71. Enter the total number of RANDOM STAFF who were interviewed:	8
72. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No

74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	The GLC has eight (8) employees who engage with residents. The PAQ provided a Table of Organization, which was used as a baseline for staff to be interviewed. Of the eight staff who engage with residents, the auditor interviewed all, or 100 percent. All staff were present, and available during the onsite audit phase. The auditor experienced no barriers to ensuring all roles and responsibilities were represented among the staff interviewed.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	7
76. Were you able to interview the Agency Head?	(●) Yes ( ) No
77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
78. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
79. Were you able to interview the PREA Compliance Manager?	( ) Yes ( ) No (●) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

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

	☐ Other
81. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
82. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
83. Provide any additional comments regarding selecting or interviewing specialized staff.	The PAQ indicated that GLC had no volunteers, or contract staff, due to the Covid-19 pandemic. In-person resident visitation was also suspended. Staff at the GLC, who routinely engage with residents are case managers. One case manager is also identified as the Intake coordinator; a second was identified as responsible for conducting resident Risk Screenings; the SOS/MT Supervisor conducts initial Risk Screenings, and is trained to conduct PREA investigations. The GLC program director is the PREA coordinator, and is trained to conduct PREA investigations. During onsite interviews, the auditor utilized random, and specialized protocols for those with dual responsibilities.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

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

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

89. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	The GLC facility opened in 2009, built as a Recovery Kentucky (RK) program. Other sites are similarly built; 50% of GLC's funding comes from KY DOC, 50% from federal Housing and Urban Development (HUD), which are considered HUD “apartments” , and have a reimbursement funding structure. According to the CEO, approximately 90-95% of GLC's budget is DOC and HUD. Apartment [second floor] units are structured as two-person "apartments", with a kitchenette, shower/restroom, along with two twin beds, a small table/chairs, and dressers for personal belongings. During the onsite audit phase, the PREA coordinator guided the auditor, and assistant through all areas of the facility. The facility has three levels, accessible via stairs, or elevator, which is restricted to use by disabled residents and/or staff. HUD requires a lock on each apartment door; however GLC requires doors to be unlocked, and hallway cameras span the length of the floor. A Peer Mentor (paid former residents) is posted at the end of the hall at all times, and is responsible for reporting any program violations, as well as assist residents with questions, requests they may have. The auditor observed room 213, which is handicap equipped. In addition to "apartments", the facility has dorm-style units with shared shower/ restrooms. These units are for residents earlier in the program, and have fewer privileges. Residents who may experience relapse are sent to the Residential Treatment Center, and may be re-admitted once medically cleared. Resident visitation has been suspended since the pandemic began. Privileges are based on program progress, and may include off-site visitation, employment. First floor dorm units are near case management offices, which are along the hallway. The auditor observed Room 121, Intake Dorm (1st floor). The dorm contains 19 beds, mostly bunk-style, a dedicated restroom with three

sinks, one handicap stall and 1 regular stall. Four individual shower heads with individual curtains. A pass-through space with cabinets containing scrubs for clients and double sinks leads to Corbett Intake Dorm with a second sleeping room with 16 bunk beds; office are located across from staff case manager office and case manager supervisor's office.
Room 132, Risk/Re-focus room is where an alleged victim would be placed, and contains four bunk beds. The space is primarily used f or residents who completed the program, but have relapsed, so they can get off the street (homeless). The GLC receives no funding for these four beds.
Resident apartments may be occupied by only one person; unoccupied rooms are not locked from the outside. Residents in lower level rooms with no dedicated shower may utilize shower facilities of an unoccupied apartment, or a friend's (with an apartment), with permission, for hygiene/self-care. Apartments, or rooms not properly maintained, or room lights left on, results in a "failed bedroom chore" violation; six violations results in being placed in the cafeteria during "down time", with a writing assignment related to the resident's behavior. A 2nd floor laundry room is accessible to residents, who are responsible for maintaining bedding, personal items (e.g., clothes).
Staff walk-through's are conducted hourly; Peer Mentors are assigned to report issues, concerns to staff. A large classroom contains pool tables, card tables for use after 6:00pm. Use of the elevator requires a medical pass, or is only used by physically disabled individuals.
The third (3rd) floor contains 23 rooms. The auditor observed Room 328 is a handicap room, and is close to the elevator. A camera in the center of the hallway covers both ends of the hall. Residents in Phase 2 have completed required programming, and able to job seek, and seek housing. Once a certain level of the program is complete, TV's are permitted in the room. Lamps are provided to

	ensure compliance with KYDOC related to proper room lighting. Clients who complete Phase 2 of the program are able to job seek, and seek housing opportunities. Clients in the Safe Off the Streets (SOS) program wear scrubs. Movement is controlled, and no recreation is permitted. The SOS program period is up to 23 days. Clients in the Motivation track (MT1) wear regular clothes, may watch TV, and participate in recreation time after treatment hours (after 6pm). The average time in this phase is 3-5 weeks. Residents in the MT2 level phase are permitted to attend Alcoholics Anonymous (AA) meetings in the community nightly. They may receive a Day Pass, which allows time in the community from 9am - 5pm on Saturday and Sunday. The average time in this phase is 3-5 weeks. During Phase 1, residents attending community meetings six nights per week, and receive an 8-hour pass on Saturday, and Sunday. Passes may be provided for Friday at 6pm - Sunday 6pm. Residents must check-in on Saturday night, and attend a mandatory AA meeting on Saturday at 6pm. This phase averages four months in duration. During Phase 2, residents have the option to begin job seeking, find stable living, or become a Peer Mentor at GLC. Peer Mentors are paid $75 per week, and average three-month terms. Most terms end after nine months; those with no stable living locations may continue at GLC. Peer Mentors are provided with daily meals, water, cable TV; residents manage their money independently.

Documentation Sampling

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

90. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No
91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	During the onsite audit phase, the auditor requested, and was provided access to electronic, and hard copy records of: • Resident Screening/re-screenings • Employee files • Resident files The auditor verified compliance with related standards. Deficiencies were identified, and documented for corrective action.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

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

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

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	1	1	1	1
Staff-on-inmate sexual abuse	0	0	0	0
Total	1	1	1	1

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

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

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

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

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

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

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

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

Sexual Harassment Investigation Outcomes

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

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

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

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

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

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	1

99. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
101. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
102. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
104. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes ( ) No (●) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

105. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. Explain why you were unable to review any sexual harassment investigation files:	The PAQ indicated that GLC has had no (0) allegations of resident sexual harassment in the past 12 months. No investigative files were uploaded in the PAQ related to resident sexual harassment. During the onsite audit, the PREA coordinator stated there have been on sexual harassment allegations at GLC in the past 12 months. The auditor reviewed one PREA investigative file, which was uploaded in the PAQ. The auditor identified the allegation as resident-on-resident sexual abuse. During interviews with 16 residents, no resident disclosed sexual harassment, or reporting such, at GLC, or to any external entity.
107. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0

109. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
110. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
112. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
113. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)

114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	The PAQ indicated there was one allegation of resident-on-resident sexual abuse. The file was uploaded in the PAQ. The Kentucky DOC conducted the investigation, and reported the information to the GLC PREA coordinator. The GLC PREA coordinator attempted to reach the alleged victim, who was housed in a local jail when the allegation was reported, but the person had been released, and was not responsive to attempts to communicate. The finding was that the allegation was Unsubstantiated.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

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

Non-certified Support Staff

116. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	◉ Yes ○ No
a. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1

AUDITING ARRANGEMENTS AND COMPENSATION

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

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

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Transitions Community Confinement Standards Policy (i.e., master PREA policy), Updated July 2021 2. Agency Table of Organization Interviews: 1. PREA Coordinator Findings: 115.211(a) The facility provided in the Pre-Audit Questionnaire (PAQ) a PREA master policy. The policy mandates zero tolerance against sexual abuse, and sexual harassment. The agency has a supplemental Sexual Assault Action Plan that supports the general policy, with five procedural areas of focus to implement the agency's

approach:
1. Zero Tolerance
2. Staffing Issues
3. Employee Training
4. Client Education
5. Prevention

The policy contains definitions of prohibited behaviors, which coincide with PREA standards. The policy Section 115.211 states:

"***(a) The agency mandates a zero tolerance policy towards all forms of sexual abuse and sexual harassment.The following describes the agency's approach to preventing, detecting, and responding to such conduct. See the agency's sexual assault action plan. 1) Implementation of the overall PREA program for all Transition's facilities is primarily the responsibility of the agency PREA Coordinator. Each facility's Program Director will serve as the facilities PREA manager. This PREA manager is responsible for ensuring agency PREA policies are being followed and reporting all incidents to the agency PREA coordinator. Additional responsibilities include informing the agency PREA Coordinator of any high risk clients, ensure all clients receive monthly PREA training refresher, ensure all staff receive ongoing PREA training at staff meetings at least 4 times per year, and finally to ensure assessment screenings are completed on clients within 72 hours, within 30 days, and when new information is learned or the client is involved in a PREA incident. 2) The agency PREA Coordinator will regularly review staffing plans and PREA policies to make adjustments where necessary (at least annually). The Coordinator will also conduct incident reviews of all PREA incidents. The Coordinator will stay in contact with the state PREA Coordinator regarding any changes in the law.***"

Based on the evidence provided, the facility meets this provision.

115.211(b)
The facility indicates in the PAQ that a PREA coordinator has been appointed to oversee compliance with PREA standards. The PREA policy requires a PREA Coordinator be appointed to oversee the agency's compliance with PREA standards, and that the position is an "upper-level" position with the appropriate authority to carry out the appointed duties. The policy states in Section 115.211:

"***(b) The agency designates Associate Operations Director Aaron Wagner, as the agency wide PREAcoordinator. The coordinator shall have sufficient time and authority to develop,implement,and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. Specifically, the job duties related to the role of PREA coordinator will be priority over others.***"

The facility provided in the PAQ a facility Table of Organization for management positions in the agency. The PREA coordinator position is currently held by Brandon

	Suhr, whom reports to the facility treatment director (department head), which is second to the Chief Executive Officer (CEO) (Agency Head). The PREA policy identifies the role of the PREA coordinator as follows: ***2) The agency PREA Coordinator will regularly review staffing plans and PREA policies to make adjustments where necessary (at least annually). The Coordinator will also conduct incident reviews of all PREA incidents. The Coordinator will stay in contact with the state (Kentucky Department of Corrections) PREA Coordinator regarding any changes in the law.*** During the pre-audit phase, the PREA coordinator was the designated point-of-contact (POC) who reached out to the PREA auditor, and coordinated with the CEO on the audit schedule. The PREA coordinator was designated to complete the PAQ, and upload documentation. During the onsite audit phase, the PREA coordinator greeted the auditor, who was accompanied by an administrative support person. The PREA coordinator was the auditor's primary contact while onsite. This person led the auditor through the onsite facility review, answered questions, and provided requested information. The PREA coordinator's office is near the facility director, and is where employee files are located. The auditor and support staff were provided a workspace inside a conference room, adjacent to the Peer Monitor office. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action recommended.

115.212	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) Interviews: 1. Agency Head Findings: 115.212(a) The facility does not contract with other facilities for the confinement of their clients. The facility indicated on the PAQ that N/A is the applicable response to this

	standard. The facility PREA policy states in Section 115.212: **"*This section is not applicable. Transition's Inc does not contract with other entities.*"** The facility's PREA policy states that standard 115.212 does not apply, as GLC does not contract with another facility for the confinement of their clients. During the onsite audit, the agency CEO confirmed during his interview that the organization does not contract with an outside entity for the confinement of residents. He stated the Grateful Life Center (GLC) is contracted with the Kentucky Department of Correction (KYDOC) to provide residential programming and services for adult males. KYDOC is the primary referral source for housing residents at the GLC facility. GLC's oversight agency, Transitions, operates other locations, one of which is across the street from the GLC, which serves as another recovery housing (acute care) site. No contracts for residential services were provided. Based on the evidence provided, the facility meets this provision. 115.212(b) The facility PAQ indicates GLC does not contract with other facilities for the confinement of their clients. The Agency Head explained in his interview that if GLC maximized their bed/population capacity they would not accept new admissions until space became available. GLC has been contracted by the KYDOC to house Commonwealth-referred (KYDOC) residential clients whom are known to have substance use issues. He further explained that GLC is a recovery housing facility, not a correctional facility. The facility is required to comply with PREA standards due to receiving referrals from the Commonwealth's Department of Corrections. Based on the evidence provided, the facility meets this provision. Corrective Action: No corrective action is recommended.

115.213	**Supervision and monitoring**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA policy 2. GLC Staffing Plan 3. Staff Review 2021/2022 Interviews: 1. Facility director

2. PREA coordinator

Site Review Observations:
1. Physical layout of the facility

Findings:
115.213(a)
The facility PAQ affirms there is a staffing plan in place. The PREA staffing plan was provided in the PAQ as supportive documentation to indicate compliance with this provision. The facility PREA policy indicates an established staffing minimum, to ensure the sexual safety of clients. PREA policy Section 115.213 states:

"***(a) For each facility, the agency has developed a staffing plan that provides for adequate levels of staffing and video monitoring, to protect clients against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, the agency has taken the following in consideration:***

(1) The physical layout of each facility;

(2) The composition of the client population;

(3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and

(4) Any other relevant factors."

The facility submitted in the PAQ an updated PREA Staffing Plan, dated August 2022, which provides a detailed outline of how the Plan considers:

- The facility physical layout;
- The composition of the resident population;
- The prevalence of substantiated and unsubstantiated incidents of sexual abuse;
- Any other relevant factors.

The staffing plan is divided into four sections:

- Staffing
- Daily Client Average
- Video System
- Staffing Plan Review

There's a minimum staffing level of no less than one Monitor (security staff) at any given time, and schedules at least two Monitors, including weekends. Daytime staff work eight-hour shifts, while overnight staff work 10-hour shifts. According to the PREA coordinator, assessing adequate staffing levels and the need for video is based on the facility layout, and number of incidents in the past 12 months. During the facility site review, the PREA coordinator provided to the auditor a facility staff

schedule employee Roster for August 2022. The Roster lists three operational shifts:

1st shift: 7:00AM - 3:00PM
2nd & 3rd shift: 2:00PM - 10:00PM; 10:00PM - 7:30AM
Weekend 1st shift: 7:00AM - 7:00PM
Weekend Overnight shift: 7:00PM - 7:00AM

The roster reflects two Monitors on each shift. During 1st shift, management and administrative staff are on-site. The Staffing Plan also covers how video technology is utilized, including the capacity of surveillance system memory. The Plan details the core four components to be reviewed at least annually to ensure the sexual safety of clients:

"***...1) the staffing plan itself, 2) prevailing staffing patters (sic), 3) the deployment of video monitoring systems and other monitoring technologies, or 4) the allocation of facility/agency resources to commit to the staffing plan to ensure compliance.*** "

Based on the evidence provided, the facility does not meet this provision.

115.213(b)
The standard provision states:
b) In circumstances where the staffing plan is not complied with, the facility shall document and justify all deviations from the plan.

The GLC PREA policy states in Section 115.213:

"***(b) In circumstances where the staffing plan is not complied with, the facility shall document and justify all deviations from the plan. The agency PREA coordinator must be notified, along with the facility's point person.***"

During his interview, the facility PREA coordinator explained that security staff (Monitors) reside at the facility. They have completed the GLC program, and are paid a stipend, plus provided room and board. The auditor observed Monitors posted on each floor of the facility during the day, and at night. During informal conversation with a Monitor, the auditor inquired about the apparent high level of trust by management that they will not only maintain order, bu report a client who violates facility rules. The Monitor stated that the facility program is about supporting each other for long-term sobriety, and a productive life style. Allowing other clients to do things they shouldn't would probably be a risk to that client's being successful in his program, but would jeopardize the opportunity being a Monitor offers: being a positive example, and showing addiction doesn't have to take over your life. The PREA coordinator also stated that GLC is not a correctional facility, but a therapeutic/recovery environment. Monitors are regarded as success stories, which encourages other clients to stay focused, and do well in their program. When asked about policy violations, he stated if a violation occurred, it would likely be an individual relapse. In such a case, clients may be returned to prison, or sent to jail (if on probation/parole); however, such is a rare occurrence with a Monitor.

	The auditor interviewed six non-security staff. Each person stated the GLC staffing structure and pattern is effective, and that there is not a prevalence of policy/rule violations, other than minor disputes that occasionally flare up. They expressed that the facility operates with safety as an ongoing priority, and that Monitors will report violations if/when they occur. Based on the evidence provided, the facility meets this provision. 115.213(c): The standard provision states: (c) Whenever necessary, but no less frequently than once each year, the facility shall assess, determine, and document whether adjustments are needed to: (1) The staffing plan established pursuant to paragraph (a) of this section; (2) Prevailing staffing patterns; (3) The facility's deployment of video monitoring systems and other monitoring technologies; and (4) The resources the facility has available to commit to ensure adequate staffing levels. The facility provided in the PAQ the facility PREA policy as supportive documentation. The policy states in Section 115.213: "***(c) Once each year with the assistance of the agency PREA coordinator, the facility will assess, determine, and document whether adjustments are needed to:*** ***(1) The staffing plan;*** ***(2) Prevailing staffing patterns;*** ***(3) The facility's deployment of video monitoring systems and other monitoring technologies;*** ***(4) The resources the facility has available to commit to ensure adequate staffing levels.***" The facility provided documented evidence that the GLC Staffing Plan is reviewed, at least annually. The document is dated to reflect when each review occurred. Two documents provided indicate the Staffing Plan was reviewed by the PREA coordinator on 6/13/2021, and 7/5/2022. The document indicates the four components of 115.213(c) were assessed, and a final determination is noted in each component, based on said assessment. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.215	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: Staff files: 1. GLC PREA policy 2. GLC New Employee Training Guide 3. GLC Employee Training Sample 4. GLC Employee PREA Refresher training sample(s) Interviews: 1. Non-Medical Random Staff Site Review Observations: 1. Auditor site observations of Operational Procedures Finding: 115.215(a), (b) The facility PAQ response indicates that 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. GLC's PREA policy Section 115.215 states: "***(a) Staff shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening). No strip search shall be performed without prior permission from the agency head.***" Staff orientation training records were uploaded in the PAQ as supportive documentation. The auditor reviewed the *New Employee Training Guide*, provided as evidence of the training content. The document states in Section 23.b., Pat Downs, that strip searches are not permitted, and must be approved in advance by the agency CEO if such is deemed necessary. The auditor interviewed the CEO, who stated he has not approved a strip search of a GLC client. The auditor reviewed 16 client files, and found no evidence of notes, or other documentation indicating an approval to conduct a strip search. The auditor reviewed eight staff orientation training records as evidence that this provision is included. Each record is signed, dated. The dates coincide with the employees' start date. The training also included appropriate transgender searches, and first responder duties During interviews with five (5) random non-medical staff, all stated they participated in a PREA training during their initial orientation, and routine PREA refreshers, which included conducting client pat-searches. When asked about searches of transgender or intersex clients, all 5 staff stated the training they received in orientation, and refresher (those whom completed both) included training for conducting pat-

searches on transgender or intersex clients, even though GLC only houses male residents. Staff unanimously stated the facility doesn't allow client body cavity searches.

During the onsite facility review, the auditor had informal discussions with staff and clients regarding transgender pat-searches. The auditor asked staff to describe what would be the process for conducting a pat-search on a transgender female client who had fully-developed breasts, and wore a bra. All staff indicated they would know what to do. One male staff stated he would ask the client if she would rather a female staff conduct such a search. The auditor asked staff what exigent circumstance would require them to conduct a cross-gender strip, or cross-gender visual body cavity search; staff could articulate what would constitute an exigent circumstance, but reiterated that policy prohibits male staff to search female residents (if a client identified as female).

During the onsite facility review, the auditor observed clients being searched who were returning from outside meetings, etc.. Searches were conducted in view of security cameras, in the front of the main lobby. In all cases, a male staff conducted the pat-search; it is noted that GLC security, and supervisory staff who engage with clients are all male. One of three case managers is a female; others have administrative, and support roles. No staff was observed strip searching any client.

GLC is an adult male facility. There are no female clients in the facility. Based on the evidence provided, the facility meets this provision.

115.215(c)
The facility indicated in the PAQ that it does not conduct cross-gender strip searches and cross-gender visual body cavity searches, and that there are no female clients at the facility. During the site review there were no female clients observed in the facility. Based on the evidence provided, the facility meets this provision.

115.215(d)
The facility indicated in the PAQ that policies and procedures are in place, which enable clients to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances. The PREA policy states in Section 115.215:

"***(d) Clients have the right to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine “house checks.” Staff of the opposite gender must knock and announce their presence when entering an area where clients are likely to be showering, performing bodily functions, or changing clothing. This includes client bedrooms. Specifically, staff should knock, then state “female/male on the floor,” then enter the room.***"

Non-security female staff are required to announce themselves, should they have a need to enter the housing units ("Female on the floor"). During the facility review,

	the PREA coordinator lead the auditor into the dorms/rooms, and announced our presence. The auditor did not observe other female staff, both security and non security, enter the client rooms/dorm. Of the five (5) monitors interviewed, all stated female staff rarely enter client rooms, but if there's a need, they announce themselves prior to entering the client dorm/room area. Administrative female staff have no regular engagement with clients that would require them to go to a client's room: case management meetings usually occur in the case managers' office. During client interviews, 16 of 16 clients stated female staff do not enter their rooms, which have dedicated restrooms and showers. They all corroborated staff statements that they are given privacy to take care of personal hygiene needs, and dress/undress. All clients stated that they are required to be dressed when in common areas, and that privacy is respected by staff. Clients stated they usually dress in the shower area, or at their bedside, if alone in their room. Three clients stated the facility staff are very strict, and will write a violation if they exit their room partially undressed (e.g., undershirt without an outer shirt). During the facility review, the auditor observed the dorm unit (Room 121), which consists of 19 beds, ranging from single twin-sized beds, to bunk beds. An adjacent restroom contains three sinks, one handicap stall and 1 regular stall. Four single showers have solid curtains. A pass-through space contains cabinets with scrubs for clients. Double sinks in the pass-through space leads to Corbett intake dorm, with a second sleeping room containing 16 bunk beds. Nearby case manager and supervisor offices are occupied by all male staff. Based on the evidence provided, the facility meets this provision. 115.215(e) The facility PAQ indicates it meets this provision, although it houses no transgender clients. The PREA policy Section 115.215(e) states: "***(e) Staff shall not search or physically examine a transgender or intersex client for the sole purpose of determining the client's genital status. If the client's genital status is unknown, it may be determined during conversations with the client, 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.***" During random staff interviews, all staff stated training is provided on how to properly conduct a pat-search of a transgender or intersex client. The PREA coordinator stated the facility has not had a transgender or intersex client. During a review of 16 client files, documentation indicated that no clients identified as female, or Intersex. Client demographic information contains check boxes for the client to self-identify as a transgender male or female. There is a check box for sexual orientation. During 16 client interviews, no clients self-identified as transgender or intersex. Based on the evidence provided, the facility meets this provision. 115.215(f)

	The facility PAQ indicates 100 percent of staff are trained on how to conduct cross-gender pat-down searches in a professional and respectful manner. Training attendance sheets, dated from 2/8/2022 to 5/10/2022, were provided as supportive documentation. The PREA policy states staff are trained on how to conduct cross-gender pat-down searches and searched of transgender and intersex clients to ensure professionalism and to utilize the least intrusive manner possible consistent with security needs. The PREA coordinator stated during interview that there have been no transgender clients housed at GLC since he became PREA coordinator five year ago. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.216	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC PREA Policy 2. GLC MOU for interpretive services 3. Staff Coverage Memo 2020 Interviews: 1. Agency Head 2. Random Staff Site Review Observations: 1. Housing unit common areas, control room, case management office area, common areas, public entrance to building, and visitation 2. Posted materials, English and Spanish 3. GLC Client Handbook, English and Spanish Findings: 115.216(a) The facility indicates in the PAQ that it complies with this provision. GLC PREA policy Section 115.216(a) states: "***(a) The agency has taken appropriate steps to ensure that clients with***

***disabilities (including clients 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. Specifically, the language line (800-873-9865) can be accessed 24/7 and offers translation of multiple languages to English, via the phone. The agency, not the client, will be responsible for any associated costs. A list of employees with specialized training in languages and sign language has also been created as another resource. If a staff member is not available the agency has several local for hire interpreters available. In addition, the agency has ensured that written materials are provided in formats, such as Spanish, or through methods that ensure effective communication with clients with disabilities, including clients who have intellectual disabilities, limited reading skills, or who are blind or have low vision.*"**

The agency CEO stated in his interview that the facility director, and PREA coordinator are designated to coordinate and provide needed support services to vulnerable client populations. He further stated that local probation and parole offices, or KYDOC would coordinate with GLC to provide interpretive services if a client was not English proficient. During random staff interviews, staff stated the facility director or PREA coordinator would decide on the appropriate resources for clients with any type of special need.

The facility website does not offer facility information in other than English. During the onsite facility review, the auditor observed via PREA posters, a 24/7 hotline number: 1-800-928-3335, which is listed as a confidential crisis hotline number. The auditor called the number, and the responder identified the entity as the Ion Center (formerly the Women's Crisis Center), and provided a website address as *ioncenter.org*. The responder stated that they provide bi-lingual staff, who would assist a caller who is not English proficient. These services are available Monday - Friday from 9:00am - 7:00pm. On weekends, or weekdays after 7pm, the Center utilizes Pacific Interpretation (3rd party), which would connect on a 3-way call with Ion Center staff in order to assist the caller. The responder stated they can provide interpretive services in many different languages besides Spanish. During the onsite facility review, two '*No Means No (and Yes is Not allowed)*' posters, in English and Spanish, with crisis hotline information, was observed throughout the facility - in the hallway entrance to the dining hall; client dorm/room areas on floors 1 and 2; in the front lounge area, Monitor office, client bulletin board on floor 1, and pay phone banks.

During the onsite audit, there were no new client intakes. However, a resident meeting was observed, whereby the staff responsible for client 30-day reassessments was reviewing PREA guidelines, facility rules, and client rights. The auditor interviewed 16 clients during the onsite facility review. Of those interviewed, all who's stay at GLC exceeded 30 days stated they had a reassessment done, and at least one group PREA refresher. No clients identified as non-English proficient, or for whom English is a second language. Questions were asked related to physical, or

	mental disability, including cognitive limitations. Two of 16 clients stated they had a physical disability, and one disclosed having a mental health issue. All three indicated they understood PREA information provided, and that their disability would not hinder their ability to report an allegation of sexual misconduct. Based on the evidence provided, the facility meets this provision. 115.216(b) The facility PAQ indicates that there are steps in place to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to clients who are limited English proficient. The PREA policy states in Section 115.216(b): "***(b) The agency will 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 clients 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.***" The auditor verified that the Ion Center Crisis hotline staff will provide to clients an individual to provide interpretive services, upon request. Based on the evidence provided, the facility meets this provision. 115.216(c) GLC's PREA policy states it will not rely upon clients as interpreters, readers, or other types of assistants except in limited circumstances that could impact a client's safety. The facility PAQ indicates the facility complies with this standard. During the onsite facility review, notices as to how clients could receive interpreter, or language assistance, in Spanish, or other language, were observed posted in the client dorm/room areas, and common spaces throughout. During random staff interviews, staff stated that there is a process in place to ensure the facility doesn't rely on other clients to interpret when a client has a need. The auditor interviewed 16 clients. Of the 16 interviewed, none identified as requiring interpretive services. Based on the evidence provided the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.217	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

The following evidence was analyzed in making the compliance determination:

Documents:
1. GLC master PREA Policy
2. 10 Staff files
3. MOU with North Key Community Care 2015

Interviews:
1. Human Resources Director
2. PREA coordinator

115.217(a)
The facility PAQ indicates that the agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. The GLC PREA policy is uploaded as supportive documentation. The policy states in Section 115.217:

"***(a) The agency will not hire or promote anyone who may have contact with clients, and shall not enlist the services of any contractor who may have contact with clients, 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."

During the onsite audit, the auditor interviewed the human resources (HR) director. The HR director stated, as it relates to hiring, the GLC employment application specifically asks applicants to disclose past involvement in allegations of sexual abuse in a correctional facility, or other institution (as defined in 42 U.S.C. 1997). She stated that PREA-related questions is part of the interview process. The auditor reviewed GLC's employment application, and observed the application asks applicants to respond to questions that coincide with the three PREA related screening components of this provision. The facility employment application form explicitly states in this section, "***Failure to disclose will result in termination of***

***employment. Be detailed!!!*"**

The HR director stated during her interview that no contracted services would be enlisted to someone who may have contact with clients who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997). Such would be discovered through background checks, references, or interviews. The same was stated as it relates to actual, or attempted sexual abuse allegations
in the community.

The auditor reviewed nine employee files during the onsite audit. Of the nine files reviewed, all, or 100 percent, contained the agency's PREA overview, and zero tolerance policy, which covers client sexual abuse, sexual harassment, and retaliation. Based on the evidence provide, the facility meets this provision.

115.217(b)
The facility PAQ indicates it complies with this provision. The facility PREA policy was provided as supportive documentation of its compliance with this provision. The policy states in Section 115.217:

"*(b) The agency will 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 clients.*"

The Agency employment application also covers an applicant's involvement with a prior allegation(s) of sexual harassment. The HR director stated an allegation of sexual harassment wouldn't be an immediate barrier to an employment, or promotional opportunity, if the allegation wasn't substantiated. Based on the evidence provided, the facility does not meet this provision.

115.217(c)
The facility PAQ indicates criminal background checks are required for new hires who may have contact with clients. The facility PREA policy section 115.217 states:

"*(c) Before hiring new employees who may have contact with clients, the agency will:*

(1) Perform a criminal background records check; and

***(2) Consistent with Federal, State, and local law, will 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.*"**

The HR director stated during her interview that the Commonwealth of Kentucky's Administrative Office of the Courts conducts a pre-employment criminal background checks for GLC. The PREA policy states the facility will make it best efforts to contact all prior institutional employers for information on substantiated allegation of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The PAQ indicates

there were two (2) new hires in the past 12 months. The auditor reviewed 10 staff files. Two reflected new hires in the past 12 months. Based on the evidence provided, the facility meets this provision.

115.217(d)
The facility PAQ indicates criminal background checks are required of those hired as contractors, who engage with clients. The GLC PREA policy Section 115.217 states:

"*(d) The agency will also perform a criminal background records check before enlisting the services of any contractor who may have contact with clients.*"

The PREA coordinator stated during his interview that the Commonwealth of Kentucky's Administrative Office of the Courts conducts a Criminal background check for GLC, including contractors who may have contact with clients. The auditor did not review a contractor file, as no contractors were hired in the past 12 months. The HR director corroborated this during her interview. During staff interviews, none of the 10 staff interviewed identified as a contractor. Based on the evidence provided, the facility meets this provision.

115.217(e)
The facility PAQ indicates criminal background checks are updated every five years. The facility PREA policy was provided as supportive documentation. Policy section 115.217 states:

"*(e) The agency will conduct criminal background records checks at least every five years for current employees and contractors who may have direct contact with clients.*"

The HR director stated in her interview that the Employee Census is reviewed monthly to determine when five-year criminal background check updates are due. She stated the KY Administrative Office of the Courts conducts the five-year background checks. The auditor reviewed 10 employee files while onsite. Of the 10 files reviewed, one (1) employee was due for an updated background check in October 2022; one (1) employee was due for an updated background check in September 2019; one (1) employee was due for an updated background check in August 2014, and 2019. six (6) of 10 files were inside five years of employment, and did not contain a follow-up criminal background check. Based on the evidence provided, the facility does not meet this provision.

115.217(f)
The facility PAQ indicates compliance with this provision. The facility PREA policy was provided as supportive documentation. The policy states in Section 115.217:

"*(f) The agency will also ask all applicants and employees who may have contact with clients, 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 also*

***imposes upon employees a continuing affirmative duty to disclose any such misconduct. Employees must report any arrest, citation without an arrest for a misdemeanor or felony, or citation without arrest for a serious violation (such as driving under the influence, alcohol intoxication, public intoxication), within 24 hours to their supervisor.*"**

No documentation was provided to support the assertion of compliance. The auditor reviewed the GLC employment application, provided by the PREA coordinator. The application form does not ask, or require applicants to affirm the required information in section (a) of this standard. The application form asks the three questions cited in provision (a) of this standard. However, no documentation was provided to affirm that employees have a continuing affirmative duty to disclose any such misconduct. No documentation was provided to indicate if, or how questions are asked of internal promotional candidates.

The auditor did not observe performance evaluations in employee files; none contained documented employee affirmation of duty to report prior allegations of sexual abuse or sexual harassment. There is no evidence that this provision has been implemented into the hiring, or promotion process. Based on the evidence provided, the facility does not meet this provision.

115.217(g)
The facility PAQ indicates material omissions, or falsification of information related to prior allegations of sexual abuse, or sexual harassment, is grounds for termination. The facility PREA policy was provided as supportive documentation. Policy section 115.217 states:

"*(g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for immediate termination.*"

The auditor was not provided files of terminated employees for review. The PREA coordinator stated during informal conversation that no employees were terminated in the past 12 months for material omissions, or falsification of information related to prior allegations of sexual abuse, or sexual harassment. He stated that an employee would be immediately terminated if the HR director found such to have occurred. Based on the evidence provided, the facility meets this provision.

115.217(h)
The facility indicates in the PREA policy, Section 115.217:

"*(h) Unless prohibited by law, the agency will 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.*"

The HR director stated in her interview that there have been no requests from institutional employers on information related to substantiated allegations of sexual abuse against a former employee. The auditor was not provided with terminated files, whereby the facility received a request for information related to

a former employee's substantiated allegation of sexual abuse while employed at GLC. Based on the evidence provided, the facility, by default, meets this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:
1. Include in employee files updated background check documentation at least every five years.
2. Develop a standardized form to document as part of performance evaluations for current employees, the employees' continuing affirmative duty to disclose prior allegations of sexual abuse, or sexual harassment. Ensure the form is signed and dated, and included in the employees' file.

FACILITY RESPONSE:

115.217(e): The facility has re-vamped the background check process, whereby criminal background checks are updated at least every five years. The following (new) documents were provided as supportive documentation:

- Updated policy 405: Personnel - Background Checks: this policy includes in the PREA Section that staff criminal background checks are required to be updated at least every five years.
- Background Check forms - Two updated background check forms were provided, which were conducted by the Kentucky Administrative Office of the Courts, Records Unit, as the facility has only two employees whom have been employed at GLC for five or more years.

115.217(f): Affirmative Duty to Disclose: The facility provided a (new) form, Prison Rape Elimination Act (PREA) Annual Acknowledgement /Review. The form reiterates GLC's zero-tolerance policy for all forms of sexual abuse and sexual harassment. The form is provided to current employees during their performance evalulation process, and requires a continuous affirmation to report any involvement with an incident of sexual abuse or sexual harassment.

Based on the evidence provided, the facility is in compliance with this standard.

Review:

Policy 405

Annual PREA Acknowledgement and Review form

Updated Criminal Background Checks (2)

115.218	Upgrades to facilities and technology
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) Interviews: 1. Agency Head 2. Facility Head Site Review Observations (not an all-inclusive list; see the report Narrative for more information): Housing dorm housing unit common areas Main security/control room main hallway/lobby (in front of the control room) facility main entrance outdoor recreation area 'Area 51' cafeteria Findings: 115.218(a) The facility PAQ indicates there have been no upgrades to the facility since the last PREA audit. During the onsite audit, the PREA coordinator was able to show the video monitoring system, and how footage can be captured onto a flash drive. The system covers 21 cameras, including views on the outside perimeter, kitchen, laundry, group/activity room; rear storage room entrance, and full view of the designated smoking area; inside main entrance. There is full view of the main hallways on floor 1; a Monitor is stationed on floor 2, which covers the area of the hallway that cameras do not. Clients sign in/out, and receive medications (locked inside a cabinet) at the control room counter, which can be viewed on a monitor in the PREA coordinator's office. Based on the evidence provided, the facility meets this provision. 115.218(b) The Agency Head stated that when he considers the facility layout, and physical aspects, a major consideration is the staff's ability to monitor client movement in, and around the facility, and the use of technology to monitor the entire facility. He stated the facility director and PREA coordinator have remote access to the video surveillance system, and routinely reviews random video footage in the facility. He stated he trusts that he stays on top of the technology, and that the facility is effectively monitored inside, and out. The facility director stated during his interview that there have been no expansions or modifications of the facility in the last 12 months. During the onsite audit the

	auditor observed the network room, which houses video monitors for 21 security cameras. No cameras have audio capacity. The network room houses 21 cameras, with views of the outside perimeter, kitchen, laundry room, group/activity room, entrance to, and full view of, client designated smoking area, and inside client dorm/room entrances. There is a full view of the main facility entrance from the control room front window. The auditor observed clients signing in/out at the front security desk. Based on the evidence provided, the facility meets this standard. **Corrective action:** No corrective action is recommended.

115.221	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA Policy 2. GLC PREA Sexual Assault Action Plan document 3. MOU between GLC and North Key Community Care 4. PREA community resource: Ion Center for Violence Prevention (formerly Women's Crisis Center) Interviews: 1. PREA coordinator 2. Random Staff Site Review Observations: PREA signage with community-based resource(s) Finding: 115.221(a) The facility PAQ indicates the facility conducts administrative investigations of reported allegations of client sexual abuse. GLC does not conduct criminal investigations. The PAQ indicates the facility follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The facility PREA policy is provided as supportive documentation for compliance with this provision. The policy states in Section 115.221: "***(a) When a sexual abuse incident occurs and physical evidence is***

***involved, staff must follow the agency's evidence protocol. The preferred method of dealing with evidence is to secure the area by keeping staff and clients out. For example, if the incident occurs in a bedroom, the room should be blocked off and no one allowed access. Probation and Parole or the local law enforcement agency handling the investigation will immediately be contacted to secure and take the evidence into their custody. However, if circumstances do not allow for proper securing of the scene, or if law enforcement is not available to respond in a timely manner, staff must secure the evidence in evidence bags. Each facility has been provided evidence bags that must remain in the front office. Staff should use gloves when placing evidence into the bags. Evidence bags should be immediately sealed and the chain of custody on the front of the bag must be filled out. The Program Director is responsible for securing the evidence until it can be turned over to law enforcement. At no time should staff take evidence home, leave it unsecure in a common area, or destroy it.*"**

The facility provided in the PAQ (not for this standard) the Sexual Assault Action Plan. The document outlines on page 3, in the Section titled, *Learning of a Possible PREA Incident*, five (5) steps for immediate response to sexual abuse:
1. Separate the abuser and victim(s)
2. Secure and protect the crime scene, if applicable
3. Notify the program director and PREA coordinator
4. Follow Uniform Evidence Protocol procedures
5. Contact KYDOC Probation and Parole and request a criminal investigation

The Plan document also provides detailed action steps, including victim emotional support, ensuring potential evidence is not contaminated, and separately transporting the alleged abuser, and victim.

During the onsite audit, the auditor interviewed 10 random and specialized staff. All staff were able to articulate the five protocol steps outlined in policy, and Sexual Assault Action Plan. All staff identified the PREA coordinator, or program director as points of contact, if a sexual abuse is reported, or observed. The facility uploaded in the PAQ a PREA training powerpoint presentation, which outlines five (5) steps, as stated above in this narrative. The auditor reviewed nine employee files. Nine of nine contained signed, and dated PREA training. Dates coincide with the employees' individual start date. The employee files also include the facility PREA overview, and explanation as to why GLC is required to comply with PREA standards. Based on the evidence provided, the facility meets this provision.

115.221(b)
The facility PAQ indicates it does not house youth, and the provision is not applicable. Auditor observation indicates there are no youth housed at this facility. The PAQ indicates a Uniform Evidence Protocol is utilized, which is 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. The facility PREA policy was provided as supportive documentation. The policy states in Section 115.221:

"***(b) The agency will offer all victims of sexual abuse access to forensic medical examinations whether at an outside facility, without financial cost, where medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. St Elizabeth hospitals have several SANE nurses on staff that can handle these types of examinations at the request of law enforcement. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency PREA coordinator will coordinate these efforts with the law enforcement agency handling the investigation.***"

Based on the evidence provided, the facility, by default, meets this provision.

115.221(c)
The facility PAQ indicates clients who allege sexual abuse will receive forensic examinations by a Sexual Abuse Nurse Examiner (SANE), or Sexual Abuse Forensic Examiner (SAFE). The facility PAQ indicates in the master PREA policy, Section 115.221:

"***(c) The agency will attempt to make available to the victim, a victim advocate from a rape crisis center. For Northern Kentucky facilities, referrals will be made to the Women's Crisis Center and/or North Key. For the Ashland facility, referrals will be made to Pathways. If a rape crisis center is not available to provide victim advocate services, the agency shall make available a qualified staff member from a community based organization or a qualified agency staff member.***"

The facility PAQ indicates forensic examinations are conducted by SAFE/SANE where possible. The MOU with North Key Community Care was provided as supportive documentation.

The facility PAQ indicates there has been one allegation of client sexual abuse in the past 12 months. The allegation involved a client inappropriately touching another client (his roommate) on the inner thigh. The allegation was deemed as unsubstantiated, and the alleged victim was no longer housed at GLC when he reported the allegation. Facility records indicate that the alleged abusive client successfully completed his program. According to investigative documentation, the client did not request, or receive medical services related to a sexual encounter with the identified client. The investigative report indicates KYDOC Probation and Parole located the alleged victim and notified the GLC PREA coordinator of his whereabouts. Based on the evidence provided, the facility, by default, meets this provision.

115.221(d), (e)
The facility PAQ indicates it attempts to make available to the victim a victim advocate from a rape crisis center, either in person or by other means. The facility

uploaded an MOU between GLC and North Key Community Care as supportive documentation. The facility PREA policy states in Section 115.221:

"***(d) 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.***

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

The auditor observed a signed MOU between GLC and North Key Community Care. The agreement states that North Key will provide to GLC victims of sexual abuse, mental health support and counseling, and referral for desired medical resources. The auditor spoke with an operator at North Key, as well as at the Ion Center. Each stated their role with respect to providing client victims of sexual abuse emotional support, including accompanying the client victim to the hospital, and referrals for services not provided by GLC. Based on the evidence provided, the facility meets this provision.

115.221(f)
The facility PAQ indicates it complies with this provision. The facility does not conduct administrative AND criminal sexual abuse investigations. The facility PREA policy states if the alleged sexual abuse is deemed to be criminal, the local law enforcement, or KYDOC Probation and Parole will be contacted for further investigation. The Uniform Evidence Protocol states in the Sexual Assault Action Plan that staff will immediately contact KYDOC Probation and Parole and request that they conduct a criminal investigation. The facility director stated during his interview that local law enforcement or KYDOC will be contacted in the event a sexual abuse allegation is considered to be criminal.

The auditor reviewed one investigation of reported sexual abuse in 2022. There was no evidence that the KYDOC was contacted to conduct a criminal investigation. During review of the investigative documentation, the PREA coordinator stated to the auditor that law enforcement was not notified, since the alleged victim was already housed at a local jail (Kenton County Detention Center) when KYDOC Probation and Parole was aware of his whereabouts. Based on the evidence provided, the facility meets this provision.

115.221(g)
The auditor is not required to audit this provision.

115.221(h)
The facility PAQ response is that it complies with this provision. During the onsite audit, the auditor reviewed a MOU between GLC and North Key Community Care. The signed agreement states that North Key will provide emotional support, and/or

	mental health counseling for an alleged victim of sexual abuse. Based on the evidence provided, the facility meets this provision. Based on the overall evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.222	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire 2. GLC master PREA Policy 3. GLC Website: https://www.transitionsky.org/ 4. GLC Sexual Assault Action Plan - Uniform Evidence Protocol Interviews: 1. Agency Head 2. Investigative staff Finding: 115.222(a) The facility PAQ indicates all allegations of sexual abuse, and sexual harassment are administratively investigated, unless such is deemed to be criminal. The facility PREA policy, provided as supportive documentation, states: "***(a) The agency will ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment through an institution/action plan. This plan is reviewed annually with existing staff, upon hire of new staff and a copy must remain in the front office of each facility.***" The facility director stated during his interview that the facility works closely with local law enforcement, and the KYDOC, which will respond to an allegation of sexual abuse, or sexual harassment, should there be an imminent threat to the alleged victim, or if it is clear a crime has been commited. The PAQ indicates there has been one allegation of sexual abuse in the past 12 months. The auditor reviewed the administrative investigation documentation. The auditor found evidence that the PREA policy and/or Sexual Assault Action Plan were followed, as KYDOC's Probation and Parole notified the PREA coordinator that the

alleged victim was housed at a local jail. The PREA coordinator stated KYDOC was contacted since the identified client victim was declared AWOL from the GLC, and may be in the community.

The Agency Head stated in his interview that there was an allegation of sexual abuse of a client by another client (roommate), and that it was investigated.
The auditor observed that the PREA coordinator conducted the 2022 administrative investigation. The auditor reviewed 10 employee files, including the file for the PREA coordinator. The auditor observed evidence that the employee received specialized training for conducting investigations of cases involving sexual victimization. The employee's file contained a signed certificate for training received as a PREA investigator, dated 12/19/2017. The PREA investigator's certificate for training received as a PREA investigator was also observed, dated 6/30/2022. Based on the evidence provided, the facility meets this provision.

115.222(b)
The facility PAQ indicates sexual abuse criminal investigations are referred to local law enforcement, or KYDOC. It states local law enforcement has the legal authority to conduct criminal investigations. The facility PREA policy supports the PAQ, and lists KYDOC as the primary entity for conducting criminal investigations.
The PREA coordinator stated during his interview that he contacts Probation and Parole to launch a criminal investigation. The facility director stated during his interview that, should there be an emergency situation, local law enforcement will be contacted, and that the agency has a good rapport with the local police.

The PAQ provides the facility PREA policy states in Section 115.222:

"***(b) The agency will refer to probation & parole, Kentucky State Police, and/or local law enforcement to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. All referrals will be documented in the incident file. The agency has published the PREA policy on its website.***"

The PREA coordinator stated during his interview he, or the first responder would call Kentucky State Police. The auditor did not observe evidence of a case being referred for a criminal investigation in the past 12 months. Once investigative file from 2022 was provided, and reviewed by the auditor. The case indicates the Probation and Parole office was contacted to locate the alleged victim, who had left GLC when he reported the allegation of sexual abuse. Based on the evidence provided, the facility meets this provision.

115.222(c)
The facility PAQ indicates KYDOC conducts criminal investigations related to allegations of sexual abuse. The facility PREA policy is provided as supportive documentation of how this process is carried out. The policy states in Section 115.222:

"***(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.*"** The auditor reviewed a PREA investigative file from 2022. The PREA coordinator stated during his interview that KYDOC Probation and Parole was contacted, but not for the purpose of conducting a criminal investigation. The client/alleged victim was not housed at GLC when he reported the alleged sexual abuse. The investigative report states Probation and Parole notified the PREA coordinator of the alleged victim's whereabouts. The PREA coordinator was able to conduct an investigation, and interviewed the alleged victim while he was housed at Kenton County Detention Center (local jail). Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.231	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA Policy 2. Staff training records Interviews: 1. Intake Staff (case manager) 2. Random Staff Site Review Observations: 1. PREA Signage through the facility Findings: 115.231(a) The facility PAQ indicates that they provide staff training on the zero tolerance policy for sexual abuse and sexual harassment during new employee orientation. The facility PREA policy was provided as supportive documentation. The PREA policy states in Section 115.231: **"*(a) The agency trains all employees who may have contact with clients on:*** ***(1) Its zero-tolerance policy for sexual abuse and sexual harassment;***

(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;

(3) Clients' right to be free from sexual abuse and sexual harassment;

(4) The right of client and employee to be free from retaliation for reporting sexual abuse and sexual harassment;

(5) The dynamics of sexual abuse and sexual harassment in confinement;

(6) The common reactions of sexual abuse and sexual harassment victims;

(7) How to detect and respond to signs of threatened and actual sexual abuse;

(8) How to avoid inappropriate relationships with clients;

(9) How to communicate effectively and professionally with clients,including lesbian,gay,bisexual,transgender,intersex, or gender nonconforming clients;

(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities."

Policy section 115.6 *Definitions* defines Sexual Abuse, Voyuerism, and Sexual Harassment, as defined in the PREA standards. The facility provided in the PAQ nine signed staff PREA policy training, dated on the start date of each employee, as evidence that training occurs at the beginning of employment. The document details the definitions reviewed, requirement for female staff to announce themselves when entering the client rooms [although currently, there are no female employees who have access to, or engage with clients at the GLC facility].

The auditor reviewed nine (9) employee files during the onsite audit. Nine, or 100 percent of the files contained PREA orientation training dated on the same date as their individual start dates, and covered first responder duties, and searches of transgender and intersex clients. A Powerpoint PREA presentation was also uploaded in the PAQ as supportive documentation. The presentation details requirements of standard 115.231, and covers the 10 core elements of how to effectively engage with clients.

Based on the evidence provided, the facility meets this provision.

115.231(b)
The facility PAQ states the training provided to staff is gender-specific for an adult-male population. The facility PREA policy states in Section 115.231:

"***(b) Such training shall be tailored to the gender of the clients at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male clients to a facility that houses only female clients, or vice versa.***"

	During the onsite review, there were no female clients were observed in the facility, or on the facility client roster. Client files supported that there are no female clients at GLC. The PREA coordinator provided to the auditor 12 signed PREA training documents. Each was signed and dated, based on when the training was conducted. Based on the evidence provided, the facility meets this provision. 115. 231(c) The facility PAQ indicates all employees who have contact with clients receive training on the agency's zero-tolerance policy. The facility PREA policy was provided as documentation of this requirement. The policy states in Section 115.231: "***(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 will provide each employee with refresher training (power point) every year to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. The agency will document ,through employee signature on a training form that employees understand the training they have received.***" The facility uploaded in the PAQ a PREA training Power point presentation used for staff refresher training. The Power point covers the 10 core elements for PREA training geared toward staff who engage with clients. During random staff interviews, all employees stated they completed PREA training on the agency's zero-tolerance policy. During the onsite review, the Auditor reviewed nine employee training records. The PREA and Zero Tolerance policy was reviewed during the time of hire for all employees. Based on the evidence provided, the facility meets this provision. 115.231(d) The facility PAQ indicates there is documentation that employees understand the content of training received. The training documents reviewed are signed, dated, and witnessed. The PREA coordinator stated in informal conversation that employees are asked if there's anything in the training they're unclear about, or do not understand. The auditor reviewed nine employee files. Of nine files reviewed, all, or 100 percent, contained a record of PREA training. The auditor interviewed 10 employees during the onsite audit. All staff stated they participated in a PREA refresher, even if they were employed less than one year. The facility states in the PAQ that PREA refreshers are conducted approximately four (4) times per year, during staff meetings. Based on the evidence provided, the facility meets this provision. Based on the overall evidence provided, the facility meets this standard. **Corrective Action**: No corrective action is recommended. **Recommendation**: Include a qualifying statement in all training documents that staff sign, which

	indicates the employee understood the information presented.

115.232	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. GLC master PREA Policy 3. GLC Uniform Evidence Protocol 4. Interviews: 1. PREA coordinator 2. Human Resources Representative 3. Formal and informal interviews with staff Findings: 115.232(a) The facility PAQ indicates it provides PREA training for volunteers and contractors. The PAQ indicates the facility has no contractors who have access to clients. The facility noted in the PAQ that the facility has had no volunteers or contractors who engage with clients since the 2020 pandemic. The facility uploaded in the PAQ a document titled, *Transitions, Inc. PREA Training Guide for the Non-Employee*, which outlines: • the facility's zero tolerance policy • definitions of sexual abuse, and sexual harassment • ways to report a PREA violation • to Whom PREA reports should be directed, by facility site • Boundaries with clients • KYDOC's policy overview No meeting notes were provided as supportive documentation, as the facility has had not volunteers or contractors who engage with clients since 2020. The human resources manager was interviewed during the onsite review. She stated that GLC has no records of any current volunteer, or contractor staff, and that such has been the case since the Covid-19 pandemic. The auditor reviewed training records of PREA training at GLC. Of 12 signed PREA training documents for staff and volunteers, three were signed by a volunteer. Each

	training document is signed, and dated prior to 2020. Training records indicate the volunteers received PREA training on 7/30/2013, 9/3/2014, and 4/22/2015. No volunteers were present during the onsite audit. Based on the evidence provided, the facility meets this provision. 115.232(b) The facility PAQ indicates volunteers and contractors receive PREA training on the agency's zero-tolerance policy. The facility provided training records of three volunteers as supportive documentation. No records identified a person as a contractor. The auditor identified in training records, documentation of PREA training on 7/30/2013, 9/3/2014, and 4/22/2015. Based on the evidence provided, the facility meets this provision. 115.232(c) The facility PAQ indicates training documentation that confirms volunteers and contractors understand the training they receive related to the facility's zero-tolerance policy against sexual abuse and sexual harassment. The facility provided PREA training documents as supportive documentation. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended. **Recommendation**: Ensure volunteer and contractor training documentation clearly indicates the individual understood the information presented.

115.233	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA Policy 2. Client files Interviews: 1. Intake Staff (case manager)

2. Random clients

Site Review Observations:
1. PREA signage through the facility

Findings:
115.233(a)
The facility PAQ indicates the agency's zero-tolerance policy against client sexual abuse and sexual harassment is reviewed with incoming clients during the intake process. Intake procedures includes reviews with clients on:

- how to report incidents or suspicions of sexual abuse or sexual harassment;
- their rights to be free from sexual abuse and sexual harassment;
- their rights to be free from retaliation for reporting such incidents;
- agency policies and procedures for responding to such incidents.

The facility PAQ provided its PREA policy as supportive documentation, which states in section 115.233:

"*(a) During the intake process, clients must 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. The client must sign the intake form in Credible that he or she understands.*"

The facility uploaded in the PAQ 12 documents signed by clients who attended a PREA review of GLC's zero tolerance policy against client sexual harassment, sexual abuse, and retaliation. The number of signatures in each document vary, based on the number of clients in the facility on that particular day (up to 85 signatures for a single session). Dates of the PREA review sessions vary from 7/1/2021 through 6/28/2022. The facility provided a PREA informational brochure by the KYDOC titled, *Understanding the Prison Rape Elimination Act (PREA) for Offenders*, which is used as a tool for the intake session.

During random client interviews, 16 of 16 clients identified the same case manager as the person, with whom PREA information was reviewed, which coincided with the staff name on each attendance sheet for the intake session. All were aware that PREA-related information was posted throughout the facility, including where client pay phones are located. Based on the evidence provided, the facility meets this provision.

115.233(b)
The facility PAQ indicates 275 clients were admitted to the facility during the past 12 months. The facility PREA policy Section 115.233 states:

"*(b) The agency will provide refresher information whenever a client is*

***transferred to a different facility. This is part of the intake process that will occur within 72 hours of arrival.*"**

The auditor did not observe a new client intake during the onsite audit, as none were scheduled during the onsite audit dates.

During random staff interviews the Intake staff stated PREA review is a prerequisite for completing orientation. He further stated that all clients attend, and the session is considered a refresher for those who have already attended the initial session during their intake; this is why there are so many attendees at each session.

During random client interviews, 16 of 16 clients were able to articulate that they received the agency's zero-tolerance policy regarding client sexual abuse and sexual harassment either upon entering the facility, or within 1-2 days of arrival. One client commented the PREA intake process began before he unpacked his belongings due to the session's scheduled start time.

During the facility onsite review, the auditor reviewed 16 client files. All files reviewed contained evidence of an initial PREA intake screening and orientation within 1-2 days of the clients' arrival. Based on the evidence provided, the facility meets this provision.

115.233(c)
The facility PAQ indicates it provides to all clients education in formats accessible to those who are: limited English proficient, deaf, visually impaired, have limited reading skills, or otherwise disabled. The facility PREA policy, Section 115.233 states:

"***(c) The agency will provide client education in formats accessible to all clients, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as clients who have limited reading skills. Facilities will keep copies of PREA material in Spanish.*"**

The PREA coordinator is identified as the position responsible for ensuring such is provided. A GLC case manager is the person assigned to conduct client intakes. During his interview, the intake staff stated he conducts client intakes within the first 24 hours of their arrival. If a client had a need for any
type of assistance, or if they knew prior to the client's arrival they had some type of physical disability, he would meet with the PREA coordinator and/or PREA investigator to arrange for the appropriate accommodation.

During the Auditor's review of client files, two clients were identified as having a physical disability. During review of the client roster, the PREA coordinator identified the same two clients as disabled. During the auditor's review of 16 client files, two files contained information identifying a client as disabled, physically, or mentally. The auditor interviewed the two [physically] disabled clients; both stated their disability would not impact their ability to report a PREA allegation, and were able to articulate ways they could report such, if necessary. Based on the evidence provided, the facility meets this provision.

115.233(d)
The facility PAQ indicates that the documents assistance or accommodation(s) provided to clients. The facility PREA policy was uploaded in the PAQ as supportive documentation. The policy states in Section 115.233:

"*(d) The agency maintains documentation of client participation in these education sessions. Every month, each facility will review the PREA policy with all clients during a house meeting. Each client must sign an attendance form and that form will be sent to the agency PREA coordinator to keep on file. This refresher is in addition to the information clients receive upon intake and/or transfer.*"

The PREA intake staff stated in his interview that he has a conversation with clients during intake about any special needs or accommodation they may have. He stated most clients do not request anything special, so there isn't usually anything to document. Of the client files the Auditor reviewed, 16 of 16 did not contain client requests for any type of accommodation, or to receive information in a special format (e.g., Spanish, braille). Based on the evidence provided, the facility meets this provision.

115.233(e)
The facility PAQ indicates key information is readily available and accessible to all clients through posters, resident handbooks, or other written formats. The facility provided in the PAQ the facility PREA policy as supportive documentation. The policy states in section 115.233:

"*(e) In addition to providing PREA education, the agency ensures that key information is continuously and readily available or visible to clients through posters and facility handbooks. PREA posters with contact phone numbers must be displayed near the pay telephones. At least one poster will be displayed on each level of the facility. The PREA policy will be displayed in a common area at all times in English and Spanish.*"

During the facility site review, the auditor observed a *Help for Victims of Prison Rape* poster, provided by the Kentucky Association of Sexual Assault Programs. The poster contains three sections of information:

- Services offered by the listed community-based resources - includes hospital accompaniment for SAFE (Ion Center); and, Emotional Support Services (North Key)
- How to Report - includes internal options to report sexual abuse and sexual harassment
- Victim Support Services - includes a hotline number and address to the Ion Center (formerly the Women's Crisis Center) as a rape crisis center (800-928-3335), and the address to North Key
- Disclaimer that communications are confidential, but that the entities are mandated reporters for child abuse, spouse abuse, and vulnerable adult abuse under the associated statutes

	Two posters, "KYDOC *Zero Tolerance, and No Means No (and Yes Is Not Allowed)* posters were observed, which contains a toll-free hotline number (833-362-PREA (7732)), which goes to the Kentucky Justice Cabinet. All three posters are posted in English and Spanish versions. During random client interviews, 16 of 16 clients were able to articulate where pertinent information is located in the facility, or to whom they go to obtain key information. Clients stated during random interviews that they knew important information is posted "everywhere" in the facility, should they have a need to report sexual abuse or sexual harassment, or retaliation. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this provision. **Corrective Action:** No corrective action is recommended.

115.234	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA Policy 2. Employee training records Interviews: 1. PREA coordinator Findings: 115.234(a) The facility PAQ indicates that those who conduct administrative investigations received training in conducting such investigations in confinement settings. The PAQ indicates two staff received specialized training to conduct PREA investigations related to reported allegations of sexual abuse. The facility PREA policy Section 115.234 states: "***(a) In addition to the general training provided to all employees pursuant to § 115.231, the agency ensures that its investigators have received training in conducting such investigations. All Program directors and Associate Operations Directors have been sent to the Department of Corrections investigator trainings and are certified investigators. All new program directors are required to obtain investigator status at the first available training class.***"

The PAQ included two uploaded training certificates of specialized PREA investigations training completed 12/19/2017 PREA coordinator), and 6/30/2022 PREA investigator/SOS/MT Supervisor), respectively. The certificates indicate the training was facilitated by The KYDOC Division of Corrections Training.

The auditor reviewed one PREA allegation investigation file from 2022. The facility PAQ indicated one allegation was received in the last 12 months. The PREA coordinator was identified as who conducted the investigation.

The auditor reviewed 10 employee files during the onsite audit. The auditor verified the two uploaded training certificates for specialized PREA investigations training was contained in the identified employees' files. Based on the evidence provided, the facility meets this provision.

115.234(b)
The facility PAQ indiates that the specialized investigations training meets all requirements of this provision: techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The facility PREA policy Section 115.234 states:

"***(b) Specialized training shall include techniques for interviewing 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.***"

The PREA coordinator is a designee for PREA-related investigations. Based on the evidence provided, the facility meets this provision.

115.234(c)
The facility PAQ indicates specialized training documentation of agency investigators is maintained. Two training certificates were provided as supportive documentation to verify such training has been received. During the onsite audit, the auditor observed the same documents in the PREA investigator and PREA coordinator training records. The auditor reviewed the investigative file of a 2022 PREA allegation. The employee identified as the investigator is one of the trained employees identified to conduct PREA investigations. Based on the evidence provided, the facility meets this provision.

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

Based on the overall evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.235	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. GLC master PREA Policy 3. Employee Roster Site Review Observations: 1. No medical or mental health practitioners at GLC Findings: 115.235(a) The facility PAQ indicates it does not have medical and mental health practitioners who work regularly in the facility. The facility did not provide supportive documentation related to medical and/or mental health services offered onsite to clients. The PREA policy, Section 115.235 states: "***(a) At this time the agency does not directly employ medical or mental health staff. However, if in the future those specialty positions are created, the agency will ensure that all 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.***" During the onsite audit, the facility provided to the auditor aGLC Organization Chart. The chart did not list any medical or mental health practitioners as employees, or contracted staff at the facility. During the onsite audit, the auditor did not observe any medical or mental health practitioners in the facility. Direct medical and mental health services are not offered at this facility. Clients are referred to the St. Elizabeth hospital, or North Key Community Care, depending on status (classification), and urgency of the situation. Based on the evidence provided, the facility, by default, meets this provision. 115.235(b) The facility PAQ indicates this provision is not applicable (N/A), as medical and/or

	mental health services are not provided at this facility. The facility PREA policy states in Section 115.235: "***(b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.***" During the onsite audit, there was no evidence of direct medical or mental health services being provided at GLC. Based on the evidence provided, the facility, by default, meets this provision. 115.235(c) The facility PAQ indicates it does not employ in-house medical or mental health practitioners. The facility PREA policy was provided as supportive documentation. The policy states in Section 115.235: "***(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.***" The PREA coordinator stated during informal conversation that clients with a need for physical/medical attention would be sent to St. Elizabeth hospital; those who desire mental health assistance would be referred to North Key. Based on the evidence provided, the facility meets this provision. 115.235(d) The facility PAQ indicates there are no medical or mental health care practitioners employed at GLC, and that the provision requirement is not applicable (N/A). The facility PREA policy section 115.235 states: "***(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.***" The Employee Roster does not list medical or mental health practitioners who volunteer or are contracted to provide medical or mental health services. During the onsite audit, there were no staff, volunteers, or contractor(s) identified as employed, or contracted to provide medical or mental health services for clients at GLC. Based on the evidence provided, this provision is not applicable to this facility. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.241	**Screening for risk of victimization and abusiveness**

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making the compliance determination:

Documents:
1. GLC master PREA Policy
2. Client files

Interviews:
1. Intake staff
2. Staff that conduct risk assessments
3. Random clients

Findings:
115.241(a)
The facility PAQ indicates that all clients are assessed during intake for their risk of sexual victimization, or sexual abusiveness. The facility PREA policy was provided as supportive documentation, which states in section 115.241:

"*All clients will be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other clients or sexually abusive toward other clients.*"

During the onsite audit, the auditor reviewed 16 client files. Of the 16 clients interviewed, all, or 100 percent stated they received an initial risk screening within the first 24 hours of arrival at the facility. One client stated he went through a PREA screening before he put away his belongings. The auditor reviewed 16 client files during the onsite audit. All files reviewed contained records of completed intake screenings. Based on the evidence provided, the facility meets this provision.

115.241(b)
The facility PAQ indicates intake screenings are ordinarily completed within 72 hours of arrival. The facility PREA policy is uploaded as supportive documentation. The policy states in Section 115.241:

"*(b) Intake screenings shall take place within 72 hours of arrival at the facility. If a client is not assessed within this time period, the agency PREA coordinator must immediately be notified with an explanation and plan.*"

The PAQ indicates the facility stated that 258 clients have been admitted in the past 12 months, whose stay was at least 72 hours, and who received an initial PREA screening within 72 hours of arrival. During random client interviews, 16 of 16 clients stated they completed their PREA intake when they first arrived at GLC. The auditor reviewed 16 client files during the onsite audit. All files reviewed contained signed intake screening documentation, dated within 24 hours of the client's arrival at GLC. Based on the evidence provided, the facility meets this provision.

115.241(c)

	The facility PAQ indicates it uses an objective screening instrument for screening clients for sexual victimization, or past sexual abusiveness. The facility PREA policy states in Section 115.241: "***(c) Such assessments shall be conducted using the approved screening instrument.that clients will be screened and assessed upon arrival.***" The PREA screening tool was uploaded as supportive documentation. The tool contains 10 questions that determine if a client is: a) known victim; b) potential victim, or c) not a victim of sexual abuse. Section II contains five (5) questions that determine if a client is: a) high risk; b) potential risk; c) no risk of being sexually abusive. The auditor reviewed 16 client files during the onsite audit. All files reviewed contained a completed screening document. Based on the evidence provided, the facility meets this provision. 115.241(d) The facility PAQ indicates clients receive a risk assessment upon admission. The facility Screening for Risk of Sexual Victimization and Abusiveness tool, and facility PREA policy are uploaded as supportive documentation. The PREA policy states in Section 115.241: "***(d) The intake screening shall consider the following criteria to assess clients for risk of sexual victimization:*** ***(1) Whether the client has a mental, physical, or developmental disability;*** ***(2) The age of the client;*** ***(3) The physical build of the client;*** ***(4) Whether the client has previously been incarcerated;*** ***(5) Whether the client's criminal history is exclusively nonviolent;*** ***(6) Whether the client has prior convictions for sex offenses against an adult or child;*** ***(7) Whether the client is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;*** ***(8) Whether the client has previously experienced sexual victimization; and*** ***(9) The client's own perception of vulnerability.***" The screening tool contains the nine criterion this provision requires to assess whether a client is one of three designated types of sexual victim or sexual abuser. The PREA Intake staff stated during his interview that If they are designated as a known victim, and appears particularly fearful, they are placed in room 132. This is an area at the end of the main hallway, near staff offices, containing four bunk beds. Clients who relapse, or return to GLC after a relapse (substance use) may also

be placed in this space until their programming can be re-determined. The screening form asks about prior sexual abuse, and whether such occurred during incarceration, or prior to incarceration. The form asks about the client's history of being sexually abusive.

During the interview, the PREA Intake staff stated no intakes, so far, have identified a client as sexually abusive. If such were identified, they would likely be placed in general population, if a high risk (for sexual victimization) person was already assigned to room 132. Based on the evidence provided, the facility meets this provision.

115.241(e)
The PREA PREA policy was provided as supportive documentation. The policy states in Section 115.241:

"*(e) The intake screening considers 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 clients for risk of being sexually abusive.*"

The PREA Screening form provided as supportive documentation indicates the screening considers, when known, prior acts of sexual abuse, or history of institutional violence or sexual abuse, or if such has been experienced, in general. The instrument considers whether a client has been convicted of a sex offense. The form asks the client about prior convictions of violent offenses. Based on the evidence provided, the facility meets this provision.

115.241(f)
The facility PAQ indicates clients are re-screened in no more than 30 days from the client's arrival at the facility. The PAQ provided the facility PREA policy as supportive documentation. Policy section 115.241 states:

"*(f) Within 30 days from the client's arrival at the facility, the facility will reassess the client's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.*"

The facility indicates in the PAQ that 227 clients were admitted who received a reassessment within 30 days of admission. The screening tool allows the screener six options for conducting the PREA screening:

- Intake with 72 hours of arrival
- Transferred in within 72 hours of arrival
- Receipt of additional information affecting Risk level
- Referral - and by whom
- Incident of Sexual Abuse
- Requested.

Sixteen (16) of 16 files the auditor reviewed contained an initial, and re-screening

within 30 days of the client's arrival date, if the client was still in the GLC program. Based on the evidence provided, the facility meets this provision.

115.241(g)
The facility PAQ indicates it conducts client risk screenings due to:

- a referral
- a request
- an incident of sexual abuse
- or receipt of additional information that bears on the client's risk of sexual victimization or abusiveness.

The facility PREA policy was uploaded as supportive documentation. The policy states in Section 115.241:

"*(g) A client'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 client's risk of sexual victimization or abusiveness.*"

No supportive documentation was provided to indicate risk assessments were conducted under these circumstances. The Intake staff stated that, screenings, outside of the initial screening, and re-screening, within 30 days of arrival have been the only circumstance for PREA screenings in the past 12 months. The Auditor reviewed 16 client files. None indicated clients had been re-screened for any reason, beyond the 30-day re-screening. Based on the evidence provided, the facility meets this provision.

115.241(h)
The facility PAQ indicates it does not discipline clients 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. The facility PREA Policy Section 115.241 states:

"*(h) Clients 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.*"

The PREA Intake staff stated during his interview that clients are not disciplined for refusing to answer risk screening questions. During the auditor's review of client files, none indicated a sanction or other violation for not responding to screening questions. Based on the evidence provided, the facility meets this provision.

115.241(i)
The facility PAQ indicates appropriate controls are in place to control 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. The facility PREA policy states in

	Section 115.241: "***(i) The agency has implemented controls on the dissemination within the facility of responses to questions asked in order to ensure that sensitive information is not exploited to the client's detriment by staff or other clients. Assessments are not to be kept in the clients file, the program director will keep them separate and secure in their office. Staff should not discuss the results of an assessment with anyone but their supervisor.***" During the onsite interview with the PREA coordinator, and PREA investigator, both stated there is limited access to client risk assessment information. During the onsite audit, client files were observed, and did not contain risk assessment information. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action**: No corrective action is recommended.

115.242	**Use of screening information**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA Policy 2. CTC Policy 800-51: Report Response 3. Client risk assessments 4. Client files Interviews: 1. PREA coordinator 2. Staff that conduct risk assessment 3. Random clients Site Review Observations: 1. Housing area 2. Program area Findings: 115.242(a) The facility indicates in the PAQ that risk screening information is used for the five purposes outlined in this provision. The facility PREA policy states:

"*(a) The agency will use information from the risk screening required by § 115.241 to inform staff and if necessary other departments within Transitions, with the goal of keeping separate those clients at high risk of being sexually victimized from those at high risk of being sexually abusive. At any time a high risk client is identified, the program director must notify the agency PREA coordinator. High risk clients will be discreetly identified on the house check form so staff is aware when they conduct their hourly house checks. Each individual high risk client will be reviewed to determine where to assign them. In most facilities, high risk clients will be assigned bedrooms on the first floor near the staff office. In some cases, high risk clients will be transferred to another facility to avoid possible conflicts. At no time will staff disclose to any client another client's risk level.*"

The facility uploaded in the PAQ the Risk screening tool as supportive documentation. The screening tool documents the initial (within 72 hours of arrival) PREA screening, and 30-day re-screening. The screening tool documents how screening information informs housing assignments, bed assignments, work assignments, education assignments, or program assignments. The PREA coordinator is required to authorize the accommodations via signature on the form. The Intake staff stated in his interview that no special accommodations have been required based on PREA screening results. The auditor reviewed 16 client files during the onsite audit. There was no evidence that special accommodations were made for clients due to the PREA risk screening result. The auditor interviewed 16 clients during the onsite audit. No client stated a need was identified for housing assignments, bed assignments, work assignments, education assignments, or program assignments, based on the risk screening result. Based on the evidence provided, the facility meets this provision.

115.242(b)
The facility PAQ indicates individualized determinations are made about how to ensure the safety of each resident. The facility PREA policy Section 115.242 states:

"*(b) The agency shall make individualized determinations about how to ensure the safety of each client. These decisions must be made with the input of the program director and PREA coordinator. High risk clients will be immediately placed in a high risk room. If no room is available or there is a conflict, an alternative room will be assigned. At times it may be determined to transfer the client to another facility for their safety. Any transfers would be made to another Transition's facility, unless unavailable. At that time the PREA coordinator would arrange a transfer to an outside agency.*"

The PREA Risk Screening tool requires the PREA coordinator to document, and authorize individual accommodations provided to a client, based on risk assessment results. The document is maintained in a separate file from the general client file. The Intake staff stated in his interview that no client assessment has warranted accommodation outside the standard placement process, based on the client's risk

	screening results. The auditor reviewed 16 client files. The auditor did not observe evidence of an alternative room assigned a client, or a transfer to an outside agency, based on the client's risk level. Based on the evidence provided, the facility meets this provision. 115.242(c) The facility PAQ indicates housing assignment decisions for transgender or intersex clients are made on a case-by-case basis. The PAQ provided the PREA Risk Assessment as supportive documentation as to how placements are made. The facility PREA policy was also provided as supportive documentation. The policy states in Section 115.242: **"*(c) In deciding whether to assign a transgender or intersex client to a facility for male or female clients, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the client's health and safety, and whether the placement would present management or security problems.*"** The PREA coordinator stated during his interview that housing assignments for transgender or intersex clients would be made based on the client's need, or request. He stated if a transgender or intersex client were referred, they would likely be housed based on program level, unless there was a concern for the client's health and safety, or if a regular assignment would present management or security problems. He stated a client who was identified as an Abuser would likely be assigned among the general population, particularly if there were a client identified as a known, or potential victim, already assigned to room 132 during the same period; a second option he stated, would be to assign the known or potential victim to the 2nd floor, and the known, or potential abuser to the 3rd floor. He stated he didn't know for sure, but is not aware of the facility having housed a transgender client. Of the 16 clients the auditor interviewed, none self identified as transgender or intersex. The auditor reviewed 16 client files. PREA risk screening documents contain client sexual orientation, and gender identity, including perceived orientation. No screening assessment identified a client as transgender or intersex. Based on the evidence provided, the facility meets this provision. 115.242(d) The facility PAQ indicates housing placements and programming assignments for transgender or intersex clients are based on the clients' own views with respect to his or her own safety. The facility PREA policy states in Section 115.242: **"*(d) A transgender or intersex client's own views with respect to his or her own safety shall be given serious consideration.*"** The PREA screening assessment tool was provided as supportive documentation. The PREA investigator, who also conducts intakes, and risk screenings, stated the facility hasn't had this type of situation (i.e., a transgender or intersex client). The auditor's review of client files, and random informal interviews did not result in identifying that any client self-identifies as transgender or intersex. Based on the

evidence provided, the facility meets this provision.

115.242(e)
The facility PAQ indicates that provisions are in place for transgender or intersex clients to shower separately from other residents. The PREA policy states GLC will make provisions to ensure transgender or intersex may shower separately from other residents. The policy states:

"*(e) Transgender and intersex clients shall be given the opportunity to shower separately from other clients.*"

The PREA coordinator stated during informal conversation that a staff restroom would be made available, as well as a shower in an unused apartment, if available. The facility did not have any clients during the time of the onsite audit, who self-identified as transgender or intersex. Based on the information provided, the facility meets this provision.

115.242(f)
The facility PAQ indicates that it refrains from placing LGBTI clients in dedicated facilities solely on the basis of the client's gender identity or sexual orientation. The facility PREA policy was provided as supportive documentation. Section 115.242 of the policy states:

"*(f) The agency shall not place lesbian, gay, bisexual, transgender, or intersex clients in dedicated facilities or bedrooms solely on the basis of such identification or status, unless such placement is in a dedicated facility or bedroom is established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such clients.*"

The PAQ provided the PREA screening tool as supportive documentation. The screening tool requires the PREA coordinator to document how screening results inform housing, programming, and other decisions. The PREA coordinator stated during his interview that LGBTI clients are not housed solely on the basis of the client's gender identity, or sexual orientation. During the process of selecting clients for interviews, the PREA coordinator identified two clients as LGBTI. During client interviews, the auditor interviewed said clients, utilizing both random resident, and targeted populations interview protocols. The clients stated during their interview they self-identified as bi-sexual, and gay, respectively during intake screening. Each stated he was not assigned to housing dedicated to LGBTI clients, nor did either perceive their bed assignment was based on their sexual orientation. Both stated his schedule is the same as other clients, and staff, nor clients have treated them disrespectfully because of their sexual orientation. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.251	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: 1. GLC master PREA Policy 2. GLC Policy 8800-51 Report Response 3. Sexual Abuse Emergency Reporting Contact Information on GLC website 4. GLC Client Handbook 5. "No Means No" postings in client hallways 6. KYDOC Zero Tolerance postings in common areas, hallways 7. ION Center web site (ioncenter.org) 8. Client files 9. Employee files Interviews: 1. Random clients (four targeted client identified) 2. Random staff 3. PREA coordinator Site Review Observations: 1. PREA signage throughout the facility Findings: 115.251.(a) The facility PAQ indicates clients have multiple internal ways for clients to report: sexual abuse and sexual harassment; retaliation by other residents or staff for reporting sexual abuse; sexual harassment; staff neglect or violation of responsibilities that may have contributed to such incidents. The PAQ provided the master PREA policy as supportive documentation. Policy Section 115.251 states: "***(a) The agency provides multiple internal ways for clients to privately report sexual abuse and sexual harassment, retaliation by other clients or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. These include verbally in person to any staff person, in writing to any staff person, the main office or DOC, OR via the 800 number to a third party. The 800 number can be found on each floor of the facility and next to pay phones. Clients are free to report to any staff person and can do so anonymously.***" The policy states clients may report to any staff, verbally or in writing, as well as via an 800 number to a third party. The auditor called the number 800-928-3335, and verified that the location of the information coincided with the policy (signage is next to client pay phones), and reached the Ion Center for Violence Prevention. The responder stated that should a GLC client contact them related to a PREA report, the

Ion Center provides emotional support, including staying with the alleged victim through a SAFE/SANE exam.

The facility provided the Sexual Assault Action Plan as evidence. The document provides an internal reporting source for PREA allegations in the Reporting section, as follows:

"***3. PREA Reports will be completed by either the Program Director of the facility or the agency PREA coordinator. Make sure to include details and be thorough. All reports should be sent to the agency PREA coordinator for review, before being forwarded on to the proper parties. PREA reports must be sent within 72 hours.***"

During the facility site review, the auditor observed posters throughout the facility, and near client phones. The auditor observed a poster titled '*Sexual Abuse is NOT Part of Your Sentence: Know Your Rights*'. Two posters are provided, one in English, and one in Spanish. The poster outlines internal steps for reporting allegations of sexual abuse, sexual harassment, and retaliation:

- Confidential PREA hotline from any offender telephone
- Verbally, to any staff person
- Have a family/friend report on your behalf

A second poster, titled '*No Means No, And Yes Is Not Allowed*', was also observed, and contains the same reporting options for clients.

During random client interviews, 16 of 16 clients stated they could report to the PREA coordinator, or case manager an allegation of sexual abuse, sexual harassment, or retaliation. Several clients gave high praise to the case manager, with whom clients stated they had a closer relationship, and felt would provide whatever assistance was needed. All clients articulated their knowledge of PREA posters throughout the facility. No client stated he didn't know of any way to report an allegation of sexual abuse, sexual harassment, or retaliation.

During random staff interviews, 10 of 10 staff (five random, five specialized staff) stated clients could report PREA allegations to them, and they would report it to the PREA coordinator, or facility (Treatment) director. All staff were aware of information on the client dorm bulletin board. Based on the evidence provided, the facility meets this provision.

115.251(b)
The facility PAQ indicates it provides at least one way for clients to report sexual abuse or sexual harassment to a public entity or office that is not part of the agency; that such entity or office is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials; and that such entity or office allow clients to remain anonymous upon request. During the facility site review, the auditor observed a poster titled, '*Zero Tolerance (KYDOC poster)*', which lists external reporting information for allegations of sexual abuse,

sexual harassment, and retaliation. The poster lists the KYDOC PREA hotline, and states reports may be anonymous. The auditor observed English and Spanish versions of the poster. The poster was observed next to client phones, in the main hallway.

The facility PREA policy Section 115.251 states:

"***(b) The agency also informs clients of at least one way to report abuse or harassment to the Kentucky Department of Corrections, which is able to receive and immediately forward client reports of sexual abuse and sexual harassment to agency officials, allowing the client to remain anonymous upon request. Clients are able to call the 800 number established specifically for PREA reports or they can contact any official with the Department of Corrections in Frankfort. Both numbers are found throughout the facility, posted at all times in common areas.***"

The auditor called the PREA hotline number 833-362-PREA (7732), and spoke with a live operator, who identified the entity as the Kentucky Justice Cabinet. The auditor identified herself, and the purpose for the call. The operator verified that GLC clients may call them for referral services, and they will notify the KYDOC, but that they do not conduct PREA investigations. The operator stated clients have the option of confidentiality, and that they will not notify the GLC of the client's identity, if the client requests to remain anonymous.

During random client interviews, clients knew they could obtain information for outside allegation reporting on the client posters, or in their folder of information, which they stated is provided to them during intake. The facility provided in the PAQ a MOU with North Key Community Care. The MOU agrees that the entity will receive client reports of sexual abuse, and assist them through referral services, including forensic medical examinations (SAFE/SANE) at St. Elizabeth hospital. The entity will notify GLC of a report of client sexual abuse, unless the client requests confidentiality. Based on evidence provided, the facility meets this provision.

115.251(c)
The facility PAQ indicates that staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties, and that such are promptly documented. The facility PREA Policy Section 115.251 states:

"***(c) Staff will accept reports made verbally, in writing, anonymously, and from third parties and shall immediately document any verbal reports. Staff must then follow the agency's action plan to begin the reporting and investigation process.***"

The auditor reviewed an investigation file from a sexual abuse allegation GLC received in 2022. The investigative report indicates the source of the allegation is the client, who reported verbally to the Intake Supervisor via phone call to GLC. The investigative information states the report was received on 4/12/22, and the alleged sexual abuse incident occurred on 4/10/22. Based on the evidence provided, the

	facility meets this provision. 115.251(d) The facility PAQ indicates that staff may privately report client sexual abuse and sexual harassment. The facility PREA policy Section 115.251 states: "***(d) The agency provides a method for staff to privately report sexual abuse and sexual harassment of clients. Staff may report to their program director or the main office verbally, in writing or by email. They may also use the 800 numbers provided by the Department of Corrections.***" During random staff interviews, all staff were articulate on first responder duties. All staff stated if a client alleged sexual abuse, the first priority would be to identify the abuser, and ensure the safety of the alleged victim. Staff indicated they would immediately contact the PREA coordinator, whether the report was received on a weekend, or at night. Staff were articulated that they could use the same 800 number as clients as another option. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. ***Corrective Action:*** No corrective action is recommended.

115.252	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. Client files Interviews: None Findings: 115.252(a) - (g) The facility PAQ indicates it does not have administrative procedures to address resident grievances regarding sexual abuse. The facility PREA policy was uploaded as supportive documentation. The policy states in Section 115.252: "***(a) The agency provides a method for staff to privately report sexual abuse and sexual harassment of clients. Staff may report to their program***

	director or the main office verbally, in writing or by email. They may also use the 800 numbers provided by the Department of Corrections.*"** No supportive documentation was provided, which indicates an administrative procedure exists. During review of client files, the auditor observed no evidence of a grievance related to allegations of sexual abuse, or sexual harassment. The facility policy does not acknowledge grievances as an option for clients to report allegations of sexual abuse. The PREA policy states in Section 115.252(b): "(3) The agency prohibits the use of the grievance process to attempt to resolve with staff, an alleged incident of sexual abuse. Any allegation of sexual abuse must be reported directly to the program director and agency PREA coordinator immediately. The grievance process is never to be used to address PREA related allegations. However, if a client uses a grievance form to report sexual abuse or harassment, staff must accept it as an alternative method of reporting abuse and immediately follow the agency's action plan.*" The PREA investigator stated during informal conversation that GLC does not conduct grievance hearings, or administrative hearings related to client reports of sexual abuse. Based on the evidence provided, the facility meets this standard. ***Corrective Action:*** No corrective action is recommended.

115.253	**Resident access to outside confidential support services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC PREA Policy Interviews: 1. Random clients Findings: 115.253(a) The facility PAQ indicates clients are provided access to outside victim advocates for emotional support services related to sexual abuse by giving clients mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations.

The GLC PREA policy, section 115.253, states:

"*(a) The agency provides clients with access to outside victim advocates for emotional support services related to sexual abuse by giving clients mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local victim advocacy or rape crisis organization, and by enabling reasonable communication between clients and these organizations, in as confidential a manner as possible. Primarily, the agency will use North Key for these services since we have a memo of understanding and routinely utilize their mental health services. We also utilize the Women's Crisis Center, and for our Ashland facility we refer to Pathways. Counselors will make a referral to North Key or Pathways as soon as it is determined that their services would be beneficial. Clients are given all related appointment time, date and contact information. Clients will fill out a release of information with the referral agency so we can follow-up and aid in the recommendations given to the client.*"

During the onsite facility review, the auditor observed information posted with contact information to outside entities where clients could contact for emotional support, and advocacy. The Auditor contacted the phone numbers listed, with the following results:

- **Ion Center for Violence Prevention** (formerly named Women's Crisis Center) (800-928-3335): spoke with a live person, who verified they provide emotional support services, and referrals to victims of sexual abuse. The operator was familiar with GLC, and stated they would assist a client who reported sexual abuse. GLC has a signed MOU with this entity.
- **North Key Community Care** (24/7 Crisis line: 877-331-3292): spoke with a live person, who verified they assist those who have been sexually victimized with mental health counseling, emergency assessments, and substance use services.

The auditor observed clients using personal cell phones in the facility. The PREA coordinator stated during informal conversation that cell phones are permitted. The auditor observed pay phones in the facility. Based on the evidence provided, the facility meets this provision.

115.253(b)
The facility PAQ indicates clients are informed of any communication monitoring. The PREA policy states in Section 115.253:

"*(b) The facility will inform clients prior to giving them access to North Key or Pathways, 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.*"

During the facility review, the auditor observed phones in the facility, which the facility does not control or monitor. During an information conversation with the

	PREA coordinator, he stated that clients have free access to phones, and calls are not monitored. Based on the evidence provided, the facility meets this provision. 115.253(c) The facility PAQ indicates there is a Memorandum of Understanding (MOU) with a community service providers that are able to provide clients with confidential emotional support services related to sexual abuse. The PREA policy was uploaded as supportive documentation. The policy states in Section 115.253: "***(c) The agency has entered into a memorandum of understanding with North Key, and we routinely refer to Pathways, both which are able to provide clients with confidential emotional support services related to sexual abuse. The agency will maintain copies of any written agreements.***" The PAQ provided a signed MOU between GLC and North Key Community Care as supportive documentation. The Auditor spoke with entities listed on facility postings, which provide such services, and verified clients have access outside more than one community resource, even though an MOU agreement exists. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. ***Corrective Action:*** No corrective action is recommended.

115.254	**Third party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1. Agency website 2. PREA Hotline (833-362-7732) Interviews: 1. Random clients 2. Random staff Findings: 115.254(a) The facility PAQ indicates it provides third-party reporting options for reporting PREA allegations. The facility PREA policy was uploaded as supportive documentation. The policy states in Section 115.254:

"*The agency has established a method to receive third-party reports of sexual abuse and sexual harassment. The PREA policy can be found on the agency's website, along with contact information for the agency PREA coordinator. Anyone from the community can submit information on the website or they can call the administrative office. Furthermore, all program directors and staff have been instructed to take all third party reports of sexual abuse and relay the information to the agency PREA coordinator for investigation.*"

The PAQ includes a comment related to this standard that external information is posted throughout the facility where client payphones are located. The agency website does not provide email access, and/or direct links to report PREA allegations. Contact phone numbers for the Ion Center, North Key, or KYDOC's PREA hotline are not identified on the facility website. The facility website contains the PREA audit report from 2019, and PREA allegations data; however, the person identified as the PREA coordinator is not the current person assigned to this role, and the facility website does not identify a PREA coordinator.

The auditor interviewed 16 random clients. All clients stated during random interviews they were aware that posted hotline numbers were to an outside, third-party, to which they could report an allegation of sexual abuse/harassment, or retaliation. Clients commented that they are comfortable reporting internally, to staff, should a need arise to do so. The auditor observed a posted external PREA hotline number in the main hallway of the facility where client phones are located (as stated in the PAQ). Based on the evidence provided, the facility does not substantially meet this provision, and standard.

Corrective Action:
1. Post the current PREA policy on the GLC website

2. Identify the PREA coordinator and contact information on the GLC website.

The facility has updated information on their website, observed by the auditor, which provides contact information for the agency-wide PREA Coordinator via phone, email. The site offers a PREA Hotline number, which may be used for anonymous reports/allegations. The GLC website (transitionsky.org) now includes four labeled links to its PREA Policy 442 (updated 4/12/2023); PREA data from 2020 - 2022; Annual PREA Report; and, PREA Zero Tolerance poster, which contains the facility's zero-tolerance policy, and PREA Hotline number (1-833-362-PREA(7732).

Based on the evidence provided, the facility meets this standard.

Review:

Policy 442

Website: transitionsky.org

115.261	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1.GLC PREA Policy Interviews: 1. PREA coordinator (also program director) 2. Random staff 3. Random residents (clients) Findings: 115.261(a) The facility PAQ indicates all staff are required to report any knowledge of client sexual abuse or harassment, retaliation, or regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation. The PAQ provided the GLC PREA policy as supportive documentation. Policy Section 115.261 states: "***(a) The agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information 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 clients or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Reporting any of these incidents must be done immediately, even if after hours or on holidays. Reporting must be by phone call if after hours, not email and not text message. If staff is unable to reach the program director within a reasonable amount of time, they should contact their Point Person or the agency PREA Coordinator.***" All five random staff respondents named the facility PREA coordinator, PREA Investigator, and/or case manager as individuals, to whom they would report a PREA allegation, regardless of whether or not the alleged incidents occurred at GLC. The auditor verified there are no medical or mental health staff at the facility. Based on the evidence provided, the facility meets this provision. 115.261(b)

	The facility PAQ states it requires staff to always refrain from revealing an 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. The facility PREA Policy Section 115.261 states: "***(b) Apart from reporting to designated supervisors, staff shall not reveal 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 decision. This includes revealing details of the incidents to other staff members not directly involved with the incident.***" Five of five random security staff stated during interviews that the PREA investigator, PREA coordinator, or case manager is who they would direct reports, and information, and that such is not to be shared with anyone. The facility Employee Roster does not identify medical or mental health staff at the facility. The PREA coordinator identified Specialized staff to the auditor during the pre-audit phase, did not identify any names related to Medical and Mental Health Staff. During the onsite facility review, the auditor did not observe, nor were any persons identified as medical or mental health staff. Based on the evidence provided, the facility meets this provision. 115.261(c) The facility PAQ indicates it complies with this provision. The PREA policy Section 115.261(c) states: "***(c) Unless precluded by Federal, State, or local law, medical and mental health practitioners are required to report sexual abuse pursuant to paragraph (a) and to inform clients of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.***" The Employee Roster indicates there are no medical or mental health staff at the facility. The MOU between GLC and North Key states it will report to GLC that an allegation of sexual abuse has been received. Based on the facility not having medical and mental health staff at the facility to report sexual abuse allegations, the auditor determines that the facility meets this provision. 115.261(d) The facility PAQ states there are no clients at GLC under age 18. The GLC PREA policy was uploaded as supportive documentation. The policy states in Section 115.261(d): "***(d) If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable person's statute, the agency will report the allegation to the designated State or local services agency under applicable mandatory reporting laws.***" The facility website states GLC is an adult male facility. During the onsite audit, no clients on the Resident roster were identified by the PREA coordinator as under age

18. Based on the evidence provided, the facility meets this provision.

115.261(e)
The facility PAQ indicates all allegations are reported to designated staff, including third-party reports. The GLC PREA Policy Section 115.261 states:

"*(e) Program directors will report all allegations of sexual abuse and harassment, including third party and anonymous reports, to the agency PREA coordinator.*"

The PREA coordinator is the facility's designated staff to receive allegations of sexual abuse, sexual harassment, and retaliation. The facility provided one investigative file from a 2022 allegation of sexual abuse as evidence. Case documentation indicates the PREA coordinator received information regarding the alleged sexual abuse. Five random staff and 16 random clients stated they would report allegations of sexual abuse to the PREA coordinator. Based on the evidence provided, the facility meets this provision.

Based on the overall evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.262	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC PREA Policy Interviews: 1. PREA coordinator 2. PREA investigator 3. Random staff Findings: 115.262(a) The facility PAQ indicates the facility will take immediate action to protect a client at risk of imminent sexual abuse. The facility PREA policy was provided in the PAQ as supportive documentation. Policy Section 115.262 states: **"*When the agency learns that a client is subject to a substantial risk of imminent sexual abuse, it will take immediate action to protect the client.***"

	***Program Directors shall immediately notify the agency PREA Coordinator of the risk. Depending on the situation, the client may be moved to a different bedroom or to a different facility.*"** During random staff interviews, five (5) of five (5) security staff stated if there was a clear threat to a client's safety, they would call the KYDOC Probation and Parole office, and notify their immediate supervisor, and/or PREA coordinator. Staff consistently articulated appropriate first responder duties to ensure the safety of the alleged victim (i.e., separate the alleged victim from an abuser, or prevent access from an identified abuser). During the onsite facility review, Room 132 (Risk/Re-focus room) was observed, which is located at the end of the main hall. There are four bunk-style beds, but no dedicated restroom/shower. The PREA coordinator stated that clients in this room have access to a staff restroom, and may shower in a friend's 2nd floor "apartment". The Auditor observed that this area can be monitored from the control room, to ensure client safety, and facility security. An alleged victim could be placed in room 132 until an investigation is concluded. Based on the evidence provided, the facility meets this standard. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.263	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC PREA Policy Interviews: 1. Agency head 2. PREA coordinator Findings: 115.263(a), (b) The facility PAQ indicates if a client reports having been sexually abused while confined at another facility, the head of the facility will be notified within 72 hours of GLC receiving the allegation. The facility PREA policy was provided as supportive documentation. The policy states in Section 116.263: "***(a) Upon receiving an allegation that a client was sexually abused while***

***confined at another facility, the program director of the facility that received the allegation shall immediately notify the agency PREA Coordinator, who will in turn notify the appropriate office of the agency where the alleged abuse occurred.*"**

During an interview with the agency head (CEO), he stated the program director, or PREA coordinator will, as his designee(s), notify the facility's designee where the alleged sexual abuse occurred. He stated he is kept abreast by the facility PREA coordinator. Policy section 115.263(b), states:

"***(b) Such notification to the other facility shall be provided by the agency PREA Coordinator as soon as possible, but no later than 72 hours after receiving the allegation.*"**

The facility did not upload in the PAQ a notification to an institution where a client disclosed during intake, that he was sexually abused at another facility/institution. The PREA coordinator, and CEO stated there had not been a report of prior sexual abuse in the past 12 months. The auditor interviewed 16 clients during the onsite audit. The PREA coordinator identified four clients who met the criteria for 'targeted' interviews. Of the options to be considered as such, none of the four had disclosed prior sexual abuse while incarcerated, or while housed at another correctional facility. Of 16, none stated, or disclosed that they experienced sexual abuse while at another facility. The auditor reviewed 16 client files, and did not observe evidence of any client reporting/disclosing prior sexual abuse while housed at another facility/ institution. Based on the evidence provided, the facility meets these provisions.

115.263(c)
The facility PAQ indicates it documents if another facility is notified (within 72 hours) that a client alleged previous sexual abuse during incarceration. The facility PREA policy section 116.263 states:

"***(c) The agency PREA Coordinator will document that notification was made.*"**

The facility provided in the PAQ no documentation to indicate that notice had been provided in the last 12 months to an institution that a client alleged sexual abuse while at that institution. The auditor reviewed 16 client files during the onsite audit phase. No evidence was observed to indicate that a client disclosed prior sexual abuse, or that such was reported to another facility/institution, and within 72 hours of GLC's knowledge of such disclosure. Based on the evidence provided, the facility, by default, meets this provision.

115.263(d)
The facility PAQ indicates the facility head or agency office that receives such notification will ensure that the allegation is investigated in accordance with these standards. The PAQ referenced the PREA policy Section 116.263 as supportive documentation. This section states:

"***(d) Any agency employee that receives such notification from an outside***

	***agency shall ensure that the allegation is investigated in accordance with these standards. They must also immediately notify the agency PREA Coordinator.*"** The policy supports what action steps GLC's PREA coordinator will take, should a report be received from another facility that their resident/inmate/detainee reported sexual abuse at GLC. The PREA coordinator stated during his interview that, should the facility receive a report from another facility that a former client alleged being sexually abused while at GLC, they would fully investigate the allegation, based on the information available. Based on the evidence provided, the facility meets this provision. Based on the overall evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.264	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-audit Questionnaire (PAQ) 2. GLC master PREA Policy 3. Client files 4. Staff training records Interviews: 1. Security staff who are first responders 2. Non-security staff Findings: 115.264(a) The facility PAQ indicates that it has a first responder policy for allegations of sexual abuse. The PAQ references the facility PREA policy as supportive documentation. Policy section 115.264 states: "***(a) Upon learning of an allegation that a client was sexually abused, the first staff member to respond to the report shall:*** ***(1) Separate the alleged victim and abuser;***

(2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;

(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and

***(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.*"**

The procedure cites four core steps involved in the Uniform Evidence Protocol plan. The steps include requesting the alleged victim to not do anything, which may contaminate physical evidence (e.g., eat, drink, urinate, defecate, wash clothes, shower, etc.), which may still exist at the scene, or on the alleged victim's body. The procedure also instructs first responders on steps to take so the alleged **abuser** (bold for emphasis) does not destroy, or contaminate evidence.

During staff interviews, five of five security first responder staff were able to articulate the core four first responder steps related to an allegation of sexual abuse, as required in this provision. Based on the evidence provided, the facility meets this provision.

115.264(b)
The facility PAQ indicates if a first responder is a non-security staff, they are required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. The facility PREA policy is uploaded as supportive documentation. The policy states in Section (b):

"*(b) The responder is required to request that the alleged victim not take any actions that could destroy physical evidence and notify their program director immediately.*"

The auditor interviewed six non-security staff during the onsite audit. All non-security staff, including management staff members, stated a sexual abuse allegation would be reported to a program director and/or PREA coordinator. All non-security staff were able to articulate first responder duties. Based on the evidence provided, the facility meets this provision.

Based on the overall evidence, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.265	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-audit Questionnaire (PAQ) 2. GLC master PREA Policy Interviews: 1. Facility director Findings: 115.265(a) The facility PAQ indicates there is a coordinated response, and there is a facility staffing plan which demonstrates the institutionalization of PREA-related procedures and protocols as part of the overall safety of the facility, and clients' sexual safety. During his interview, the facility director described the facility coordinated response as: 1) the first responder separates the victim from the abuser; 2) secure any physical evidence; 3) contact the program director, and/or PREA coordinator; 4) ensure the victim does not take any action that would destroy or contaminate evidence (e.g., do not eat, drink; urinate, deficate; shower, brush teeth; wash clothes); 5) contact 911, if immediate medical care is needed; 6) transport the alleged victim to St. Elizabeth hospital for SAFE/SANE medical examination, if necessary.. The facility PREA Sexual Assault Action Plan document was uploaded as supported documentation. The Plan includes in Section 1.e.: "***(e) Forensic Evidence – often in cases of sexual assault, forensic evidence can be located on the victim's person. In these situations, try to prevent the victim from changing clothing, using the restroom, showering, eating or drinking.***" The PREA policy states in Section 115.265: "***The agency has developed a written institutional/action plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and supervisors. The institutional/action plan is reviewed and updated on a regular basis. A copy must be displayed in the front office of each facility at all times.***" The policy references the PREA Assault Action Plan, which includes actions staff will take to ensure the alleged abuser does not destroy or contaminate evidence. During random staff interviews, 10 of 10 random and specialized staff stated they were aware of the steps they're expected to take, as outlined in Plan. The Plan was

	updated in 6/1/2022. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.266	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in make the compliance determination: Documents: 1. GLC masterPREA Policy Interviews: 1. Agency head Findings: 115.266 (a) The PAQ indicated that neither the agency nor facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. Thus, they are not restricted in the disciplinary process of staff members that have violated sexual abuse/sexual harassment policy or limited in their ability to remove staff sexual abusers. The facility PREA policy was uploaded as supportive documentation. The policy states in Section 115.266: "***(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 clients pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.***" The Agency head corroborated during his onsite interview that there is no collective bargaining agreement or other agreement between GLC and any entity. Interviews with random staff also supported this information. Based on the evidence provided, agency, by default, meets this pirovision.

	116.266(b) The auditor is not required to audit this provision. **Corrective Action:** No corrective action is recommended.

115.267	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in make the compliance determination: Documents: 1. GLC master PREA Policy 2. GLC Policy 3. Facility physical layout Interviews: 1. Agency head 2. Director or Designee 3. Designated Staff Member Charges with Monitoring Retaliation 4. PREA coordinator Findings: 115.267 (a) The facility PAQ indicates there is a policy which will protect clients and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigation from retaliation. The facility uploaded the GLC PREA policy as supportive documentation. Policy Section 115.267 states: "***(a) The agency has established a policy to protect all clients and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other clients or staff and shall designate which staff members or departments are charged with monitoring retaliation. Staff is required to immediately report to their supervisor any reports, rumors or observations of possible retaliation. Retaliation is not acceptable and will be investigated immediately. Supervisors must immediately notify the agency PREA Coordinator of any such reports. It is the responsibility of each program director to monitor and report any incidents of allegations.***" During the onsite audit phase, the auditor interviewed the PREA coordinator, who is also the designee to conduct retaliation monitoring. He stated that he would check on an a known victim daily to assure the person has experienced no retaliation by other clients or staff. He further stated that staff would report to him directly if they felt they were experiencing retaliation related to a PREA allegation, or investigation outcome. The auditor interviewed five random, and five specialized staff during the onsite audit; of the 10 interviewed, all (not counting the PREA coordinator, or CEO)

stated they would go directly to the PREA coordinator if they felt they were being retaliated against related to a PREA related allegation.

The PAQ indicates there was one allegation of sexual abuse in the past 12 months. The auditor reviewed an investigative file of a sexual abuse allegation from 2022. The report indicates there has been no retaliation monitoring, as the client was no longer a resident at GLC.

During random client interviews, none of the 16 clients interviewed stated they reported an allegation of sexual harassment against a staff person.

Based on the evidence provided, the facility meets this provision.

115.267(b)
The facility PAQ indicates it provides a policy which entitles clients to a safe environment and that all allegations are administratively, or criminally investigated. The facility PREA policy states in Section 115.267:

"*(b) The agency will employ multiple protection measures, such as room changes or transfers for client victims or abusers, removal of alleged staff or client abusers from contact with victims, and emotional support services for clients or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. These cases will be dealt with individually, considering all factors involved.*"

During the facility site review, the PREA coordinator (who guided the auditor) described an area, to the rear of the main hallway. The area entrance has signage identifying the space as Room 132. The PREA coordinator described the space's primary use as the Risk/Re-focus room. He stated that GLC clients who experience relapse after leaving the program, may return, and begin a new program, if needed. If not fully utilized, the room would house client(s) who allege sexual abuse, sexual harassment, or retaliation, should they need to be moved from their assigned room/ apartment. The area can be monitored from control room surveillance cameras, as well as from the PREA coordinator's office. The area provides access to a nearby staff restroom; clients in room 132 may use shower facilities in a 2nd floor 'apartment', with the assigned clients' permission.

During random staff interviews, five (5) of five (5) security and non security staff stated they would separate the victim from the abuser; the facility/treatment director specified placing an alleged victim in Room 132. During a review of the facility layout, and onsite facility review, a section consisting of four bunk-beds, at the end of the main hallway, was identified by the facility director as the Risk/Re-focus room. This section was identified as where a client would likely be placed, should he be fearful of sexual abuse due to prior sexual abuse (while incarcerated); threatened or actual sexual abuse, or retaliation. Clients who relapse in the community (post-program) are also temporarily placed in room 132. The PREA coordinator stated if the alleged harasser/abuser were in the facility, he would likely place the victim in room 132, to maximize the distance between the victim and abuser.

	The Agency Head stated during his interview that he would first consider the source(s) of allegation(s). He would have an alleged abuser removed during the investigation. The facility director stated a client abuser would likely be sent to the local jail. The PAQ reflects there has been one allegations of sexual abuse, or sexual harassment in the past 12 months. The auditor reviewed the investigative documentation, which indicates the identified abuser (client) remained at the facility, as the alleged victim was at a local jail when he reported alleged sexual abuse while housed at GLC. Based on the evidence provided, the facility meets this provision. 115.267(c) The facility PAQ indicates that it conducts PREA retaliation monitoring. GLC's PREA policy is uploaded as supportive documentation. The PAQ cites policy section 115.267 as evidence of the facility's procedure, which states: "***(c) For at least 90 days following a report of sexual abuse, the agency will monitor the conduct and treatment of clients or staff who reported the sexual abuse and of clients who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by clients or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any client 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.***" The facility identifies the PREA coordinator as the person responsible for retaliation monitoring. The policy doesn't specify how retaliation monitoring will be conducted. However, during interviews, the PREA coordinator stated such would occur during facility walk-throughs, and headcounts, when client wellness checks will be conducted for any client who may be a target of retaliation. During random client interviews, none of the 16 clients interviewed disclosed, or reported sexual harassment by a staff person. Client files reviewed (16) did not result in identifying evidence of clients having reported sexual abuse, sexual harassment, or or retaliation. The facility PREA policy doesn't specify a staff person responsible for retaliation monitoring; it does indicate a timeframe (i.e., minimum of 90 days), in which retaliation monitoring will continue. Based on the evidence provided, the facility meets this provision. 115.267(d) The facility PAQ indicates the facility conducts periodic status checks, and documents if periodic status check are conducted, as required by standard 115.267. The facility PREA Policy was provided as supportive documentation. The policy states in Section 115.267: "***(d) In the case of clients, such monitoring shall also include periodic status checks. The ideal time for these checks are doing (sic) individual sessions.***"

	The facility indicated during the onsite audit, that there was one reported case of sexual abuse in the past 12 months. The auditor reviewed the investigation file. The person identified as the abuser was a client who remained at GLC; the alleged victim had left GLC (unsuccessfully), and reported the alleged sexual abuse while at a local jail. The Final PREA investigative report states that the PREA coordinator made efforts for the client to contact the GLC, but the client had not responded as of 6/1/2022. Based on the evidence provided, the facility meets this provision. 115.267(e) The standard requires the facility to take appropriate action for any other person who may have cooperated and fears retaliation. The PAQ states there was one sexual abuse allegation in the past 12 months, but that no retaliation monitoring occurred, due to the client having left the GLC prior to reporting a PREA allegation. The GLC PREA policy states in Section 115.267: "***(e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency will take appropriate measures to protect that individual against retaliation.***" The facility director stated during his interview that, should a staff person fear retaliation, the person's supervisor, and/or other named staff, would be monitored to ensure such is not happening. The PREA coordinator stated during his interview that there have been no employees in the past 12 months, who reported fear of retaliation, related to a PREA allegation. The auditor reviewed six employee files, and 16 client files. The auditor did not observe any evidence of employee retaliation, or client retaliation. The auditor reviewed the GLC PREA Sexual Assault Action Plan, dated 6/1/2022, which was submitted as supportive documentation for compliance with PREA standard 115.265. Page 7, Section, "*Follow-up and Incident Review*" of the Action Plan document states: "***2. Monitoring for retaliation will continue for at least 90 days. If no reports or rumors of retaliation after 90 days, monitoring can cease. However, if there are signs of retaliation, monitoring must continue. This will be a decision made by the Program Director and agency PREA coordinator.*** ***a) Documentation – Program Directors are required to complete the retaliation monitoring form every month, for at least 90 days. This form must be turned into the agency PREA coordinator by the 1st of each month and kept on file. Note, if the allegations are found unfounded, monitoring for retaliation may end.***" The document outlines a clear process to take appropriate action for any other person who may have cooperated and fears retaliation. It includes the role of the program director who receives the information, and what they're to do with the information, and communication with the PREA coordinator.

	Based on the evidence provided, the facility meets this provision. 115.267(f) The Auditor is not required to audit this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.271	**Criminal and administrative agency investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC PREA Policy 2. GLC PREA investigative file - 2022 Interviews: 1. PREA Investigator 2. PREA coordinator Onsite facility review Findings: 115.172(a) The facility provided in the PAQ the GLC PREA Policy as supportive documentation of compliance with this standard. Policy Section 115.271(a) states: "***(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. The agency will only investigate allegations involving clients. If a staff member is allegedly involved, the PREA coordinator will contact the Department of Corrections and request that they conduct the investigation.***" The PREA investigator stated in his interview that an internal investigation would begin immediately upon receiving a report of client sexual abuse, sexual harassment, or retaliation. He further stated that the PREA coordinator is the lead

person in an administrative investigation, determines the outcome of administrative investigations, and confers with the CEO on such. Allegations, which appear to be criminal would be referred to the KYDOC to begin a criminal investigation. The PREA coordinator stated during interview that he would contact the Commonwealth's Parole and Probation Authority, depending on the client's status.

The PAQ indicates there was one reported allegation of sexual abuse in the past 12 months. The auditor reviewed the investigative file during the pre-onsite audit. The PREA coordinator confirmed during his interview that there were no investigative files to review for sexual harassment, or retaliation in
the past 12 months, including third-party, or anonymous reports. During random client interviews, no client disclosed having reported an allegation of sexual harassment against a staff person.

During the facility site review, the PREA coordinator identified the Risk/Re-focus Room (132), as where an alleged victim would be placed to separate him from an alleged abuser. He stated that the room's (containing 4 bunk beds) primary use is for clients who completed the program, but have relapsed, so they can return off the street. The facility receives no funding for these four beds.The area can be monitored via surveillance cameras in the control room, and the PREA coordinator's office. There is no dedicated restroom/shower, so clients are permitted to use a staff restroom, or may use a friend's shower, who resides on the 2nd floor.

According to the PREA coordinator, if the identified abuser is a staff member, they would be placed on administrative leave with pay, and KYDOC conducts the investigation. If the alleged abuser is a client, he would be temporarily removed, and housed under KYDOC supervision, or local jail, until the investigation is complete. Based on the evidence provided, the facility meets this provision.

115.271(b)
The facility PAQ indicates internal investigators received specialized training related to sexual abuse investigations, as per standard 115.234. Training for facility investigators was verified through supporting documentation provided by the facility. The PREA investigator, and PREA coordinator files contained certificates from the KYDOC's Division of Corrections Training, dated 12/19/2015, and 6/30/2022 for PREA Investigator specialized training. The auditor reviewed one investigative file from a 2022 allegation of staff sexual abuse. The auditor observed that the staff identified as having conducted the administrative investigation is the PREA coordinator, and KYDOC.

The GLC PREA policy Section 115.271(b) states:

"*(b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.234.*"

PREA investigations are conducted by the agency PREA coordinator, or SOS/MT Supervisor, who is trained to conduct PREA investigations. Based on the evidence provided, the facility meets this provision.

115.271(c)
The facility PAQ indicates, and documents in its PREA policy, Section 115.271, investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data. It further states that the facility will review prior complaints and reports of sexual abuse involving suspected perpetrator. Policy 115.271 Section (c) states:

"***(c) Investigators will gather and preserve direct and circumstantial evidence, including 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.***"

The auditor reviewed a 2022 PREA investigation file. The file did not contain information regarding evidence collection, as the alleged sexual conduct did not involve a physical, sex act, but that the alleged abuser "groped" the alleged victim in the groin area. The file does not document whether it reviewed prior complaints and reports of sexual abuse involving suspected perpetrator, or if such existed. The investigative report indicates the alleged victim and abuser were interviewed.

During interviews, the PREA coordinator demonstrated how video technology can be utilized as part of an investigation. During the onsite facility review, the auditor observed 21 cameras in a small room with other technology equipment, which covered internal and external areas throughout the facility. A facility layout document was provided, which reflected camera locations, and the view span of each camera, to identify blindspots in, or around, the facility. The PREA coordinator stated in his interview that physical or circumstantial evidence would be collected by local police, as part of a criminal investigation. Staff are trained to preserve, and protect physical evidence in an investigation until law enforcement takes over. Based on the evidence provided, the facility meets this
provision.

115.271(d)
The facility PAQ indicates compelled interviews will be conducted, if an allegation rises to criminal. GLC's PREA policy states:

" ***(d) When the quality of evidence appears to support criminal prosecution, the agency will conduct interviews only after consulting with the Department of Corrections and law enforcement. The agency would prefer law enforcement conduct interviews when criminal charges may be involved, however we will conduct the interviews if requested.***"

The PAQ indicates there has been one allegation (sexual abuse) in the past 12 months. The auditor reviewed a 2022 PREA investigative file. There was no evidence that the interviews with the alleged victim, or abuser were compelled to answer questions. There is no evidence that the facility requested
KYDOC to conduct a criminal investigation. Documentation reviewed indicates the client was located at a local jail, and the conduct was not deemed as criminal.

Evidence provided indicates no administrative action was taken, resulting in an Unsubstantiated determination. Based on the evidence provided, the facility meets this provision.

115.171(e)
The facility PAQ indicates the PREA policy Section 115.271 states:

"***(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 client or staff. The agency may require a client 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.***"

During interviews, the PREA coordinator stated the agency does not conduct polygraph tests, nor does it use any other truth-telling device during PREA investigations. During client interviews, none of the 16 clients interviewed expressed ever being asked to take a polygraph test; none of the 16 clients interviewed stated they experienced sexual abuse while incarcerated, or while at GLC. Based on the evidence provided, the facility meets this provision.

115.271(f)
The facility PAQ indicates 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. The facility PREA policy Section 115.271 states:

"***(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."

During interviews, the PREA investigator, and PREA coordinator all stated GLC has had no criminal investigations in the past 12 months. The PREA coordinator stated criminal investigations are conducted by KYDOC. The PREA coordinator stated the facility has a good relationship with local law enforcement, and KYDOC, in the event they're contacted related to a PREA violation. Based on the evidence provided, the facility meets this provision.

115.271(g)
The facility PAQ indicates all criminal investigations shall be documented in a written report that contains thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. The facility PREA policy Section 115.271 states:

"*(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.*"

One investigative file was reviewed to corroborate what is stated in policy, as the facility has had one reported allegation in the past 12 months. The auditor observed the case was investigated administratively, and not referred to KYDOC, although the client was housed in Kenton County Detention Center, as it was not deemed to be criminal. During interviews with the agency head, PREA investigator, and PREA coordinator, all stated this case is the only allegation of sexual abuse and/or harassment, or retaliation in the past 12 months, which was not deemed as criminal. The facility PREA policy identifies the KYDOC as the entity responsible for criminal investigations, and that such would be conducted in accordance with PREA standards.

Of the 16 client files reviewed onsite, none contained documentation related to allegations of sexual abuse and/or sexual harassment, or retaliation, which were referred to law enforcement as a criminal case. Client intake screenings did not indicate there have been reported allegations at GLC, nor were there any reports of prior sexual victimization. Review of six employee files resulted in no finding of disciplinary action, or other legal action against staff for client sexual abuse and/or sexual harassment, or retaliation, or evidence of any criminal charges for past sexual abuse, sexual harassment, or retaliation. The auditor reviewed a file from 2022, which did not involve a staff member. The auditor observed in the Final Report that the alleged abuser (client) remained at GLC during the investigation. Based on the evidence provided, the facility meets this provision.

115.271(h)
The facility PAQ indicates substantiated allegation of conduct that appears to be criminal shall be referred for prosecution. The facility PREA policy, Section 115.271 states:

"*(h) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.*"

During the onsite audit, no criminal investigation files were reviewed, as the facility has had no allegations in the past 12 months, which were deemed as criminal. There were no records in client files of court cases stemming from allegations of sexual abuse and /or harassment, or retaliation. The PREA coordinator stated during interviews that there have been no PREA-related allegations, which were deemed to be criminal, and referred for prosecution. The PREA investigator, and PREA coordinator both stated in interviews there have been no allegations, which appeared to be criminal in nature. The agency head stated the facility has had one allegation of sexual abuse in the past 12 months. Based on the evidence provided, the facility meets this provision.

115.271(i)
The facility PAQ indicates all case records associated with allegations of sexual

misconduct or retaliation shall be securely retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. GLC PREA policy Section 115.271(i) states:

"*(i) The agency will 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.*"

During the onsite audit, no records retention documentation was provided for review. No records retention documentation was provided in the PAQ. The PREA coordinator, and PREA investigator both stated there has been one allegation reported in the past 12 months. The policy's assertion that records are retained for a minimum of five years after the date of initial collection, does not provide a retention maximum. Therefore, the policy does not clearly define the facility's records retention period. Based on the evidence provided, the facility does not meet this provision.

115.271(j)
The facility PAQ indicates it ensures that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation. GLC's PREA policy is provided as supportive documentation. Policy section 115.271(j) states:

"*(j) The departure of the alleged abuser or victim from the employment or control of the agency will not provide a basis for terminating an investigation.*"

The auditor reviewed one investigation file from 2022. According to the documentation, the alleged victim unsuccessfully completed the program, and the alleged abuser remained at the facility. Based on the evidence provided, the facility meets this provision.

115.271(k)
The auditor is not required to audit this provision.

115.271(l)
The facility PAQ indicates 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. The facility PREA policy is provided as supportive documentation. Policy Section 15.271 states:

"*(l) When outside agencies investigate sexual abuse, the agency shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.*"

During the onsite audit, the auditor reviewed one investigation file, as there was one reported allegation of sexual abuse and/or harassment, or retaliation in the past 12 months. The file contained evidence of communication between the facility and an outside entity (KYDOC probation officer) regarding the investigation.

No supportive documentation regarding investigations conducted by an outside entity was provided in the PAQ.

The PREA coordinator stated during interviews that there would be ongoing communication with the KYDOC probation/parole officer, if they were investigating a PREA allegation. He further stated investigatory documentation would be submitted to KYDOC. Based on the evidence provided, the facility meets this provision.

Corrective Action:
1. Ensure the facility has a documented records retention policy, which aligns with the requirement of provision (i) of this standard as it relates to PREA investigative files.

FACILITY RESPONSE:

The facility has updated policy 405 - Personnel: Background Checks, to include that PREA investigative reports are retained for as long as the allege abuser is incarcerated, or staff is employed by the agency, plus five years (Section 5).

Based on the evidence provided, the facility meets this standard.

Review:

Policy 405

Policy 442

115.272	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC PREA Policy 2. PREA investigative file - 2022 allegation Interviews: 1. Investigative staff Findings: 115.272(a) The facility PAQ indicates it imposes a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment can be substantiated. The facility PREA policy, in section 115.272 states:

	"*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.*" The policy was provided as supportive documentation. The facility PAQ states there has been one allegation of sexual abuse in the past 12 months. The auditor reviewed an investigative file provided from 2022; the allegation was unsubstantiated based on lack of witnesses, or other evidence. There was no evidence that a standard higher than a preponderance of evidence was used to make a determination of the allegation. Based on evidence provided, the facility meets this standard.

115.273	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in make the compliance determination: Documents: 1. GLC PREA Policy 2. 16 client files Interviews: 1. Facility head 2. Investigative staff 3.16 Random client interviews Findings: 115.273(a) The facility PAQ indicates the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The facility PREA policy was provided as supportive documentation. Policy section 115.273 states: **"*(a) Following an investigation into a client's allegation of sexual abuse suffered in an agency facility, the agency shall inform the client as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. This can be verbal notification, but will usually be in written form from the agency PREA coordinator.*"** The PAQ response indicates there has been one reported allegation of sexual abuse

	in the past 12 months that was administratively investigated. The facility also uploaded in the PAQ a Final (PREA) Investigative Report, which the auditor observed to be an investigative file from a 2022 sexual abuse allegation. The investigative documentation, also uploaded in the PAQ (i.e., Notification), indicates the facility PREA coordinator attempted to provide to the alleged victim a verbal and/or written notice of the investigation's outcome. The documentation in the file indicates the Kenton County Detention Center, where the alleged victim was housed during the investigation, informed the GLC PREA coordinator that he was no longer housed at the facility. The PREA coordinator requested to the KYDOC probation officer to have the alleged victim contact the GLC. As of 6/1/2022, the alleged victim had not contacted the facility. Therefore, no documented responses to the client regarding the outcome of the investigation was provided. During the onsite audit, 16 clients were interviewed. None of the 16 clients interviewed stated they have reported an allegation of sexual abuse, and none stated they were aware of reports of alleged sexual abuse in the facility. Based on evidence provided, the facility meets this provision. 115.273(b) The facility PAQ indicates if the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, the agency requests the relevant information from the investigative agency in order to inform the resident. GLC's PREA policy was provided as supportive documentation. Policy section115.273(b) states: "***If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the client.***" The facility PAQ indicates there are no investigative files to review, where outside agencies conducted an investigation regarding alleged client sexual abuse. GLC's PREA Policy states KYDOC's probation and parole office will investigate sexual abuse allegations deemed to be criminal. The PREA coordinator stated during his interview that there have been no sexual abuse allegations, which were investigated by KYDOC. Based on the evidence provided, the facility meets this provision. 115.273(c) The facility PAQ indicates upon completion of an inmate sexual abuse allegation against a staff member (unless unfounded) the PREA coordinator shall inform the resident of the following: • The staff member is no longer posted within the inmate's unit; • The staff member is no longer employed at the facility; • The institution learns that the staff member has been indicted on a charge related to sexual abuse within the institution; • The agency learned that the staff member was convicted on a charge related to sexual

abuse within the facility.

The GLC's PREA Policy was uploaded as supportive documentation. Policy Section 115.273(c), states:

"***(c) Following a client's allegation that a staff member has committed sexual abuse against the client, the agency shall subsequently inform the client (unless the agency has determined that the allegation is unfounded) whenever:***

(1) The staff member is no longer assigned within the client's facility;

(2) The staff member is no longer employed by the agency;

(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."

The policy section includes all components outlined in this provision. The facility PAQ indicates there has been one sexual abuse allegation in the past 12 months, which involved another client. The auditor reviewed the investigative file during the pre-onsite audit. The Sexual Abuse Incident Review indicates the client was not notified of the investigation's outcome, due to his whereabouts being unknown. The PREA coordinator stated during his interview that he conducted the investigation. The auditor observed documentation in the file that attempts were made to notify the alleged victim of the outcome via request to the client's probation officer. However, the client never responded to the PREA coordinator's request. Based on the evidence provided, the facility meets this provision.

115.273(d)
The facility PAQ indicates that 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. All such notifications or attempted notifications shall be documented. The facility PREA policy is provided as supportive documentation. Policy Section 115.273 states:

"***(d) Following a client's allegation that he or she has been sexually abused by another client, 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.*"** The auditor reviewed a PREA investigation file from 2022, which stemmed from an allegation of sexual abuse by a (former) client, who identified his roommate as the alleged abuser. The PREA investigator, PREA coordinator both stated during interviews that the facility has received one reported allegations of client-on-client sexual abuse and/or harassment, or retaliation in the past 12 months. The auditor observed in the investigation file documentation of the PREA coordinator's effort to notify the alleged victim of the investigation's outcome. The documentation indicates that the alleged victim did not respond to the PREA coordinator's request, which was made via the client's probation officer. Based on the evidence provided, the facility meets this provision. 115.273(e) The facility PAQ indicates the agency has a policy that all notifications to residents described under this standard are documented. The facility PREA policy is uploaded as supportive documentation. Policy Section 115.273(e) is referenced in the PAQ, that coincides with this provision. The policy Section states: **"*(e) All such notifications or attempted notifications shall be documented.*"** The facility PAQ indicates the facility received one client allegation of sexual abuse by a staff in 2022. The facility uploaded a Notification document related to the 2022 PREA investigation file, also provided in the PAQ. The auditor observed documented reference that the client victim was not notified of the investigation outcome, due to the whereabouts of the alleged victim being unknown, despite the facility's effort to provide said notification. The document indicates that as of 6/1/2022, GLC had not been contacted by the alleged victim, and that the PREA coordinator had made attempts via the client's probation officer in April 2022. Based on the evidence provided, the facility meets this provision. 115.273(f) The Auditor is not required to audit this provision. Based on the evidence provided, the facility does not meet this standard. Corrective Action: No corrective action is recommended.

115.276	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50: PREA and Zero-Tolerance 2. Employee Roster: February 2020 3. 13 Employee files Interviews: 1. Facility director/Human Resources Findings: 115.276(a) The facility PAQ indicates all staff shall be subject to disciplinary sanctions up to, and including termination for violating agency sexual misconduct policies. Policy 800-50 is uploaded as supportive documetation. Policy section IV. 1. A. states all staff shall be subject to disciplinary sanctions up to, and including termination for violating agency sexual misconduct policies. It further states that a substantiated allegation against a staff shall result in immediate termination. Section IV. 1. B. states any contractor, intern or volunteer who engages in sexual misconduct is prohibited from contact with clients and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and also to relevant licensing bodies. The facility director is also responsible for overseeing the human resources function for the agency. He stated during his interview that CTC terminated an employee in the past 12 months, due to alleged sexual abuse with a client. The auditor reviewed an investigative file during the onsite audit. The file, provided to the auditor by the PREA coordinator, involved a staff in an inappropriate relationship with a client in 2019. The auditor reviewed documented evidence that the alleged staff abuser was terminated. No files for volunteers were provided for review. During the onsite audit, the Employee Roster provided, from which the auditor made random and specialized staff interview selections, identified one person as a contractor. The contractor's file reflected PREA refresher training on 2/7/2020. Based on the evidence provided, the facility meets this provision. 115.276(b) The facility PAQ indicates that termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Policy 800-50, which serves as the facility's Zero-

	tolerance policy, was provided as supportive documentation. Policy section IV. 1. A. states all substantiated allegations result in termination, as the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Section IV. 1. A. states all staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual misconduct policies. The auditor observed in the provided 2019 investigative file, documentation for 103 discplinary action (termination) against the employee named in the sexual abuse allegation. The PREA coordinator stated during her interview that immediate termination would be imposed, should it be substantiated that a staff engaged in sexual abuse, while on the clock (actively working). Based on the evidence provided, the facility meets this provision. 115.276(c) The facility PAQ indicates that disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed. Policy 800-50 states, "All staff shall receive disciplinary sanctions up to and including termination for violating facility sexual misconduct policies." The PAQ indicates there has been one PREA allegation in the past 12 months. The auditor reviewed the investigation file of the sexual abuse allegation from 2019. The investigation resulted in the identified employee's termination. During his interview, the facility director stated there have been no other allegations in the past 12 months, whereby an employee was disciplined. The auditor reviewed 13 employee files. None contained evidence of disciplinary action for violating the agency's zero tolerance policy. Based on the evidence provided, the facility meets this provision. 115.276(d) The facility PAQ indicates all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies. Policy 800-50 was provided as

	supportive documentation. Policy section IV. 1. A., states, "...All terminations for violations of agency zero tolerance policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies unless the activity was clearly not criminal, and also reported to any relevant licensing bodies." The PAQ indicates no terminations for violating the agency's zero tolerance policies were reported to law enforcement, unless the activity was clearly not criminal. Ohio Revised Code 2907.03(A)(11) states sexual conduct between a person in a detention facility and an employee of that facility, is sexual battery (paraphrased). Section (B) of the same, states violations of the Code is a felony of the third degree. The auditor reviewed one sexual abuse investigation file, from 2019, during the onsite audit. The investigation documentation did not contain evidence that the facility reported to Lancaster Police that an employee was terminated for allegations of sexual abuse. Based on the evidence provided, the facililty does not meet this provision. Corrective Action: 1. Implement, and document, the requirement in policy 800-50, section IV. 1. A., that all terminations for violations of agency zero tolerance policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies unless activity was clearly not criminal. FACILITY RESPONSE: The facility provided policy 800-50, which indicates in Section IV. 1. A. that law enforcement is to be notified when a substantiated sexual abuse allegation involves an employee, unless the activity was clearly not criminal. 104 No documentation was provided to verify the implementation of the policy, as there have been no sexual abuse allegations during the corrective action period. Based on the evidence provided, the facility, by default, meets this standard. Review: Policy 800-50 105

115.277	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC policy 800-50 PREA and Zero Tolerance Interviews: 1. Facility director Findings: 115.277(a) The facility PAQ indicates agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies.agency's response on the PAQ indicated that Agency policy does not require that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. It further indicates that agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. Policy 800-50,provided as supportive documentation, states in Section IV. 1. B., that any contractor, intern, or volunteer who engages in sexual abuse/harassment is prohibited from contact with clients and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and also to relevant licensing bodies. The PREA coordinator stated during her interview that there are no files for volunteers. During the auditor's review of the Employee Roster, no volunteers were identified. One contractor was identified. A personnel file review determined the clinical director (contractor) completed PREA refresher training on 2/7/2020; PREA training was also verified in 2019. Based on the evidence provided, the facility meets this provision. 115.277(b) The facilitiy PAQ indicates the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency

	sexual abuse or sexual harassment policies by a contractor or volunteer. Policy 800-50, uploaded as supportive documentation, states in section IV. 1.B., "The agency shall take appropriate remedial measures, and terminate the contract, intern arrangement, or volunteer arrangement with independent contractors, interns, or volunteers, or shall demand that the offending employee of a contractor be excluded from providing services under the contract." The facility provided no volunteer files to review for compliance with the agency's policy. The facility director stated in his interview that there were no volunteers providing services at CTC. One contractor file contained evidence of completed PREA Zero Tolerance policy training, and PREA refresher training. No volunteers were observed in the facility during the onsite audit. Based on the evidence provided, the facility meets this provision. 106 Based on evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended. 107

115.278	Disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC policy 800-50: PREA and Zero Tolerance 2. CTC Client Handbook 3. Client files 4. Agency Table of Organization 5. Client Sanction Receipt (2019 investigation) Interviews: 1. Facility Director Findings: 115.278(a) The facility PAQ indicates residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in

	resident-on-resident sexual abuse; residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-onresident sexual abuse. The PAQ further states there have been no administrative findings of resident-on-resident sexual abuse that have occurred at the facility in the past 12 months; there have been no criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility in the past 12 months. Policy 800-50 was provided in the PAQ as supportive documentation. The policy indicates in section IV. 1. C. that "clients shall be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative and/or finding that a client engaged in client-on- client sexual abuse/harassment." During the last 12 months, there were no allegations with an administrative finding of client-on-client sexual abuse that occurred at the facility, and there were no criminal findings of guilt for client-on-client sexual abuse that have occurred at the facility. During the onsite audit, the PRE coordinator provided to the auditor a copy of the CTC Client Handbook, as documentation of client accountability. On Handbook pages 11-17, violations and sanctions are addressed and coincide with a violation code table. There are six violation codes: 1. Automatic referral to Behavioral Review Committee (A) 2. High (H) 3. Moderate High (MH) 4. Moderate (M) 5. Low Moderate (LM) 108 6. Low (L) The Handbook states on page 11, "The Behavioral Review Committee will determine the sanctions to be applied to the violations and/or referral to the Bureau of Community Sanctions. Sanctions can range from internal restrictions to removal from the program...". Sexual Misconduct is listed as a category of unacceptable behavior. There are three general types of prohibited sexual misconduct, each tagged with the applicable Violation Code: 1. Non-consensual sexual conduct or contactwith another whether compelled: 1. By force (A) 2. By threat of force (A) 3. B intimidation other than threat of force (A)

	4. By any other circimstances evidencing a lack of consent by the victim (A) 2. Consensual physical contact for the purpose of sexually arousing or gratifying either person (MH) 3. Seductive or obscene acts including indecent exposure or masturbation; including, but not limited to any word, action, gesture, or other behavior that is sexual in nature and would be offensive to a reasonable person (MH) Consequences for non-consensual client-on-client sexual conduct is documented, and communicated with facility clients. Each client receives a Client Handbook during Intake. The facility has a formal Behavioral Review Committee, which reviews client violations, and determines the level of sanction. During the auditor's review of 17 client files, no sanctions were identified for client-on-client sexual misconduct. The PREA coordinator stated in her interview that there have been no allegations of client-on-client PREA allegations in the past 12 months. Based on the evidence provided, the facility meets this provision. 115.278(b) The facility PAQ indicates 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 residents with similar histories. Policy 800-50 is provided as supportive documentation. Section IV. 1. C., states, "Clients shall be subject to disciplinary sanctions following an administrative and/or criminal finding that the client engaged on client-on-client sexual misconduct. When determining the appropriate disciplinary sanction, CTC shall take into consideration any Mental Health diagnosis of the abuser." The facility Behavioral Review Committee reviews client violations, and determines the level of sanction.The facility director stated during his interview that a substantiated allegation of sexual abuse would result in the client's termination from the CTC program, and possible new charges. Lesser violations may result in a client being placed in Area 51, or the Briar Patch, or both, depending on the situation. Sanctions are not determined by one person, but the Committee; the client's history, prior violations, are considered when determining appropriate

	sanctions. Based on the evidence provided, the facility meets this provision. 115.278(c) The facility PAQ indicates when determining what types of sanction, if any, should be imposed, the disciplinary process considers whether a resident’s mental disabilities or mental illness contributed to his or her behavior. Policy 800-50 was provided as supportive documentation. Policy section IV. 1. C., states, in part, "...When determining the appropriate disciplinary 109 sanction, CTC shall take into consideration any Mental Health diagnosis of the abuser." The facility director stated during his interview that a client's mental disability would be considered as it relates to the type of sanction to be imposed. Based on the evidence provided, the facility meets this provision. 115.278(d) The facility PAQ indicates the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The auditor was provided a copy of the agency's table of organization as supportive documentation. According to the agency Table of Organization, the facility does not provide mental health services, such as therapy, counseling, or other interventions. One case manager is assigned clients with known mental health issues; interventions would be determined by the facility's referral source, ODRC, where clients have access to mental health services. The case manager facilitates linkages to services such as Tele-Med conferences between clients and mental health practitioners at a correctional institution, with which the client it connected. The Employee Roster, from which the auditor selected random and specialized staff interview selections, did not list mental health therapists, or counselors. PREA Form 1.1 does not list medical, or mental health practitioners. The facility director stated during his interview that the agency does not provide in-house medical, or mental health services to clients. Based on the evidence provided, the facility meets this provision. 115.278(e) The facility PAQ indicates a 'no' response to this provision. The PAQ asks if the

	agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. Policy 800-50 is uploaded as supportive documentation. The policy addresses client accountability for client-on-client sexual abuse, sexual harassment. The policy does not indicate whether clients receive disciplinary sanctions for sexual conduct with staff only upon finding that the staff member did not consent to such contact. The Client Handbook does not specify if violations for sexual misconduct apply to sexual conduct with staff. The facility entered in the PAQ Comment Box for this provision, "General House Rule". The auditor reviewed the Client Handbook. Rule no.15 states, as a violation, "Establishing or attempting to establish a personal relationship with an employee, contractor, or volunteer." Sub-section (d) states, "Engaging in or sosliciting sexual conduct, sexual contact, or any act of a sexual nature with an employee (H)." The auditor reviewed one sexual abuse investigative file from a 2019 allegation. The file indicates the client successfully completed the CTC program after the investigation was closed. The facility uploaded a 'Sanction Recipt' document from the investigation, signed by the client, his case manager, the staff Investigator (who conducted the PREA investigation), and the facility director. The document indicates the client in the sexual abuse allegation received disciplinary sanction for violating Rule 15. The disciplinary sanction(s) imposed were: 30 days in-house (no work, itinerary, free-time, or passes) 20 hours extra duty Phase reduction from Phase 3 to Phase 2 No visits for 30 days No phone contract for the remainder of the client's program 110 Weekly allowance reduced to $30/week Based on the evidence provided, the facility does not meet this provision. 115.278(f) The facility PAQ indicates the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if

	an investigation does not establish evidence sufficient to substantiate the allegation response affirms that client reports of sexual abuse made in good faith are not considered false reports, or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Policy 800-50 Section IV. 1. C. states, "...Clients are only subject to disciplinary sanction if an administrative and/or criminal finding that the client engaged in client-on-client sexual misconduct." The 2019 investigation file reviewed by the auditor indicates the employee involved was terminated, and the client successfully completed the program. The report indicates the source of the allegation is 'unknown'. The PREA coordinator stated to the auditor that the (female) staff admitted to a sexual relationship with the client. While the client involved did not report the sexual conduct, such was substantiated. Of the 17 client files reviewed, none contained evidence of disciplinary action imposed on a client based on an unsubstantiated allegation of sexual abuse. Based on the evidence provided, the facility meets this provision. 115.278(g) The facility PAQ indicates the agency always refrains from considering non-coercive sexual activity between residents to be sexual abuse. Rule 9, in the Client Handbook prohibits "Consensual physical contact for the purpose of sexually arousing or gratifying either person (MH)". Non-coercive sexual behavior does not constitute sexual abuse, but is considered a 'Moderate High' program violation. There were no violations of sexual misconduct in any of the 17 client files reviewed. There were no allegations of client-on-client sexual abuse in any of the 17 client files reviewed. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility does not substantially meet this standard. Corrective Action: 1. Add a qualifying statement to Client Handbook, Rule 15 (Unauthorized Relationships and Disrespect), which states client disciplinary sanctions for sexual conduct with staff is imposed only if there is evidence that the staff did not consent to such contact. FACILITY RESPONSE:

	The facility has updated the Client Handbook, Rule 15, adding in Section d. that client disciplinary sanctions for sexual conduct with staff is imposed only if there is evidence that the staff did not consent to such contact. Staff training documentation, dated 8/7/2020, was provided as verification that staff were trained on the updated language. Training documentation is dated, and includes staff signatures. Based on the evidence provided, the facility meets this standard. Review: 111 Policy 800-50 Staff training documentation CTC Client Handbook 112

115.282	**Access to emergency medical and mental health services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA Policy 2. GLC MOU - North Key Community Care Interviews: 1. Security Staff First Responder Review Observations: 1. PREA resource posters in client hallways, and common areas 2. PREA resource posters near client phones Findings: 115.282(a) The facility PAQ indicates resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The PAQ affirms that the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. It indicates further that medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. The PAQ

states, related to the latter affirmation that case managers are responsible for documenting appointments and
services clients receive related to sexual abuse. The facility's PREA policy states in Section 115.282:

"***(a) Client victims of sexual abuse will receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determine by medical and mental health practitioners according to their professional judgment. Depending on the nature of the abuse, clients will be referred to St Elizabeth or Kings Daughters Hospitals (Ashland facility). North Key and Pathways may also be utilized for mental health services if necessary. Program directors will ensure all necessary referrals are made in a timely manner and keep the agency PREA coordinator updated. Staff will follow the agency's action plan unless otherwise directed by the program director or agency PREA coordinator.***"

During the auditor's review of 16 client files, one PREA investigation was provided from 4/2022; a document was provided from an allegation in 2020. In the 2020 case, a document was uploaded in the PAQ as supportive documentation related to this standard. The document header, "Notification and offering of Victim Advocacy Services" states the alleged client/victim was offered services related to a sexual abuse case, and the client declined. The form is signed by the client, and an employee, and dated 3/26/2020.

The auditor reviewed a sexual abuse investigation file dated 4/10/2022. There was no evidence the client requested medical or mental health services. The PREA coordinator provided a 'Notification' document related to the allegation, which indicates that the client had been located at Kenton County Jail, but that he was no longer an active inmate at the facility. The PREA coordinator stated he attempted to reach the client by leaving word with this probation officer to contact the GLC PREA coordinator. As of 6/1/2022, the client had not responded. The auditor observed that the allegation did not involve physical sexual misconduct that may have resulted in a physical medical exam, but there is no indication of whether mental health services were offered at the jail, or if such was offered, if the client declined, or received any services. Based on the evidence provided, the facility meet this provision.

115.282(b)
The facility PAQ indicates it does not employ or contract with medical or mental health practitioners. The PREA coordinator stated during an informal discussion that GLC has a relationship with NorthKey Community Care, and provided a documented Memorandum of Understanding (MOU) as supportive documentation. The MOU indicates that the organization will provide mental health services for GLC clients via a Mobile Care Unit. Individual, and group Mental Health therapy may also be requested via phone mental health referrals by calling Access at 331-3292.

During the facility site review, the auditor observed a hotline phone number posted

near client pay phones. The auditor called the number 800-928-3335, which is posted as a 24/7 crisis hotline number. The responder identified the organization as the Ion Center for Violence Prevention (ioncenter.org). She stated that, should a client state the need for medical care related to a sexual abuse, they provide transportation to St. Elizabeth hospital. Clients would then be provided options related to care, advocacy, mental health, and emotional support. The facility PREA policy states in Section 115.282:

"*(b) Staff first responders shall take preliminary steps to protect the victim pursuant to the agency's action plan and shall immediately notify their program director, who will refer to the appropriate medical and mental health practitioners.*"

During the onsite audit phase, the auditor interviewed five employees who would be first responders. Five of five employees interviewed stated if a client alleged sexual abuse, they would contact the PREA coordinator, who also serves as the program director, as well as call 911, if necessary.

Based on the evidence provided, the facility meets this provision.

115.282(c)
The facility PAQ indicates 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. The PREA policy is provided as supportive documentation. Policy section 115.282 states:

"*(c) Client victims of sexual abuse 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.*"

The policy affirms the language of this provision. Based on evidence provided, the facility meets this provision.

115.282(d)
The facility PAQ indicates 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. GLC's PREA policy is provided as supportive documentation. Policy section 115.282 states:

"*(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.*"

The auditor interviewed five (5) security first responder staff. All five stated they would follow the chain of command if a client victim requested medical, or mental health treatment. Five of five stated the SOS/MT Supervisor, case manager, or PREA coordinator would take care of the victim's medical needs. The PREA coordinator

	articulated during his interview that he or the SOS/MT Supervisor would navigate the process to ensure a client was not financially responsible for a medical bill, should they report such was received. The facility response in the PAQ stated there have been no allegations where medical or mental health services were needed. The auditor reviewed documentation related to a PREA allegation in 2020, and 2022. The auditor observed evidence that, in the 2020 case, the alleged victim signed a document indicating he declined medical, or mental health services. The 2022 case was investigated and closed with the alleged victim not responding to the PREA coordinator's attempts to follow up with him after the initial interview. Based on the evidence provided, the facility meets this provision. Based on evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.283	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC PREA Policy 2. GLC MOU - North Key Community Care 3. Client files 4. Agency Table of organization Findings: 115.283(a) The facility PAQ indicates it shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. The auditor reviewed the Employee Roster to confirm the facility does not have medical staff or mental health practitioners on staff, or contracted to provide such services. The facility PREA policy states in Section 115.283: "***(a) The agency will offer medical and mental health evaluation and as appropriate, treatment to all clients who have been victimized by sexual abuse in an agency facility.***"

	The auditor observed a signed MOU with North Key Community Care. The entity will assist clients who report or disclose prior sexual abuse, with medical and/or mental health needs related to being sexually victimized. The entity will coordinate medical forensic examinations with St. Elizabeth hospital, and provide emotional support, if desired. The Intake staff stated in his interview that he in conjunction with the PREA coordinator, would arrange transportation to St. Elizabeth hospital Emergency Room, if a client disclosed prior sexual abuse while incarcerated, and the incident was recent. The PREA coordinator stated during informal conversation that if EMT were not needed, he would arrange for internal staff (if not he, himself) to transport the client to the Emergency Room to get checked out, if the client reported he had been sexually abused prior to arriving to GLC. During the onsite audit, the auditor received, and reviewed 16 client files. The PREA screening form was reviewed. The screening form asks about prior sexual victimization, including during incarceration. The screening form also asks if the client has ever been identified as sexually abusive. Based on the evidence provided, the facility meets this provision. 115.283(b) The facility PAQ indicates 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. The PAQ indicates a client's case manager is responsible for assisting with scheduling medical and/or mental health services, if desired. PREA policy Section 115.283 is provided as supportive documentation. Section 115.283(b) states: **"*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. Referrals for evaluation and treatment will be made to North Key.*"** The facility provided to the auditor a signed Memorandum of Understanding between GLC and North Key Community Care. The agreement is signed by the executive director(s) of North Key, and GLC. The agreement has been in place since 6/8/2015. The agreement identifies St. Elizabeth hospital, which is the local hospital, as where clients are referred if in need of medical services resulting from sexual abuse. The facility PAQ indicates there have been no reported allegations of sexual abuse, which required medical or mental health services. Based on the evidence provided, the facility meets this provision. 115.283(c) The facility PAQ indicates it shall provide such victims with medical and mental health services consistent with the community level of care. The GLC PREA Policy is provided as supportive documentation. Policy section 115.283 identifies a MOU with a community resource, which is accessible to client victims after the victim is no longer at the facility. The PREA coordinator identifie, during his interview St.

	Elizabeth hospital, which is the local hospital, as where clients are referred if in need of medical services resulting from sexual abuse. The PREA coordinator stated during his interview that clients, depending on the situation, may also be transported to a local Urgent Care clinic.The facility indicated in the PAQ there have no reported allegations of sexual abuse in the last 12 months, which required a client to received medical of mental health services. Based on the evidence provided, the facility meets this provision. 115. 283(d) There are no female clients at the GLC facility. The PREA policy states in Section 115.283(d): **"*(d) Client victims of sexually abusive vaginal penetration shall be offered pregnancy tests at no cost to the client.*"** The PREA coordinator stated that while such has not occurred at GLC, a transgender male who physically has female genitalia, and able to have children, would be offered a pregnancy test at no cost, should such be related to a sexual abuse situation. Based on the evidence provided, the facility meets this provision. 115.283(e) There are no female clients at the GLC facility. The PREA policy states in Section 115.283(e): **"*(e) If pregnancy results from conduct specified in paragraph (c) of this section, such victims shall receive timely and comprehensive information about access to all lawful pregnancy related medical services.*"** The PREA coordinator stated that, while such has not occurred at GLC, a transgender male, who physically has female genitalia, and who was known, or proven to be pregnant, would be provided timely and comprehensive information about access to all lawful pregnancy related medical services. Therefore, the facility meets this provision. 115.283(f) The facility indicates in the PAQ that resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. PREA policy Section 115.283(f) was reviewed as supportive documentation. Policy section 115.283(f) states: **"*(f) Client victims of sexual abuse will be offered tests for sexually transmitted infections as medically appropriate and at no cost to the client.*"** The PREA screening tool asks clients to disclose previous sexual victimization, which may have occurred during incarceration. The agency Intake staff confirmed during his interview that sexual victimization while incarcerated is part of the client PREA screening. During the onsite audit, the auditor did not observe a client Intake, as none were admitted during the onsite review. The auditor observed the client

	respond to questions pertaining to sexual abuse, or abusiveness, during incarceration. Based on evidence provided, the facility, by default, meets this provision. 115.283(g) The facility PAQ indicates that treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. PREA policy is provided as supportive documentation. Policy Section 115.283(g) states: **"*(g) Treatment services will 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.*"** The PAQ indicates there have been no reported sexual abuse allegations in the last 12 months, which involved a client needing medical treatment. During the onsite audit,16 client files were reviewed; none contained evidence that a client received medical services for an alleged sexual abuse. Based on the evidence provided, the facility meets this provision. 115.283(h) The facility PAQ indicates 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. The GLC PREA policy s provided as supportive documentation. Section 115.283(h) states: **"*(h) The agency will conduct a mental health evaluation of all known client on client abusers within 30 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.*"** The facility PAQ states there have been no reported allegations of client sexual abuse, which required mental health or medical services. During the onsite audit 16 client files were reviewed; none contained evidence that a client received medical services for an alleged sexual abuse. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.286	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making the compliance determination:

Documents:
1. GLC PREA Master policy
2. GLC PREA Sexual Abuse Incident Review Report 2022
3. PREA Investigation file (2022)
4. PREA Investigation Final repoert (2022)

Interviews:
1. Facility head
2. PREA coordinator

Findings:
115.286(a)
The facility PAQ indicates 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. The auditor reviewed PREA Policy section 115.286 as supportive documentation. Policy section (a) states:

"*(a) The agency will 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.*"

The PREA coordinator stated during his interview that three staff are trained to participate in PREA investigations:
SOS/MT Supervisor - Harry Perin
PREA Coordinator - Brandon Suhr
Treatment Director - Tony Huffman

The facility uploaded a PREA investigative report, final determination report, and Sexual Abuse Incident Review Report (SAIR) from an allegation of client-on-client sexual abuse in April 2022 as supportive evidence. The investigative report indicates that probation officer Cheryl Ritchie was also involved in the investigation. The investigative report, documented via a KDOC Community Confinement Sexual Offense Allegation Report form, states the allegation was reported to Ms. Ritchie, after the alleged victim left the GLC. The facility provided a KDOC PREA Investigative Report, which summarizes the allegation, statements from the alleged victim, and alleged abuser, and a conclusion. The PREA coordinator signed the document.

The facility PAQ indicates there was one allegation of sexual abuse in the past 12 months, which was in 2022. Supportive documentation was uploaded in the PAQ. The completed Sexual Abuse Incident Review form is signed, and dated 5/5/2022, within 30 days of the conclusion of the allegation (4/10/2022). The PREA coordinator stated during his interview that he participated in the PREA investigation, and

	interviewed the alleged victim, who was in a local jail. Based on the evidence provided, the facility meets this provision. 115.286(b) The facility PAQ indicates sexual abuse incident reviews are usually conducted within 30 days of the conclusion of an administrative or criminal investigation. The auditor reviewed the facility PREA Policy as supportive documentation. Policy section 115.286 (b) states: "(b) Such review should ordinarily occur within 30 days of the conclusion of the investigation." The facility uploaded a Sexual Abuse Incident Review Report (SAIR) form as additional supportive documentation. The auditor observed that the form is related to the investigative report uploaded in Section (a) of this standard. The form states the conclusion of the review, in relation to the investigation's initial outcome. The SAIR is dated, and signed by the PREA coordinator within 30 days of the conclusion of the administrative investigation. Based on the evidence provided, the facility meets this provision. 115.286(c) The facility PAQ indicates the Sexual Abuse Incident Review Team consists of upper-level management officials, and includes input from investigators, line supervisors, medical and mental health professionals. The facility provided the agency Table of Organization, and a completed SAIR report as supportive documentation. The Treatment (facility) director reports to the Agency Head (Chief Executive Officer). The PREA coordinator, who also serves as the primary person responsible for PREA investigations, reports to the Treatment director. The completed SAIR report identifies four individuals, including the PREA coordinator, as part of the Review team. Collectively, the team represents 'upper-level management, and investigator. The auditor was provided an allegation report for review, as there as been one reported allegation of sexual abuse in the past 12 months. The investigation file includes a Sexual Abuse Incident Review form. The document reflects the identified staff who make up the team. Based on the evidence provided, the facility meets this provision. 115.286(d) The facility PAQ indicates the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator. A documented Sexual Abuse Incident Review (SAIR) Report form, included in the PREA investigation report dated 4/10/2022 was provided as supportive documentation. The form covers the five aspects required in section (d)1-5 of this standard, each of which requires a 'yes/no', or narrative response. The form contains a response to each of the five components of this provision. The PREA

	coordinator stated during his interview that he is the designated team member to complete the SAIR Report, as part of the review team. During onsite interviews with 16 random clients, none stated they reported an allegation of sexual abuse. Review of 16 client files did not result in identifying any allegation(s) of sexual abuse. Based on the evidence provided, the facility meets this provision. 115.286(e) The facility PAQ indicates the facility implements the recommendations for improvement or documents its reasons for not doing so. The PREA coordinator stated during his interview that he normally prepares the incident review report; the SAIR document was observed by the auditor to coincide with the investigative report uploaded in the PAQ, and supports the initial investigation outcome. The facility head stated he, along with the PREA coordinator work as a team, along with other managers and relevant staff. He indicated there is a structured incident review process in place, which is supported by a documented report dated 4/10/ 2022, provided in the PAQ. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.287	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC Master PREA Policy 2. PREA 2022 Investigative file 3. GLC SAIR Report Interviews: None Findings: 115.287(a) The facility PAQ indicates the agency collects accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions. The facility's PREA Investigative Report document was provided in the PAQ as evidence of a standardized instrument. The facility PAQ indicates there has been

	one allegation of client sexual abuse in the last 12 months. The auditor reviewed one completed PREA Investigative Report from April 2022. Based on the evidence provided, the facility meets this provision. 115.287(b) The facility PAQ indicates the aggregated incident-based sexual abuse data is reviewed at least annually. The GLC's master PREA policy section 115.287 (b) states the agency PREA coordinator and other staff as designated by the CEO shall review the aggregated data for the purpose of "Preparing an annual report of the agency's findings and corrective actions". The auditor observed the agency's 2020-2022 aggregated data collection report posted on its website: https://www.transitionsky.org/. Based on the evidence provided, the facility meets this provision. 115.287(c) The facility PAQ indicates the aggregated incident-based data includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. A review of the PREA policy's Data Collection section 115.287 corroborates the PAQ response that such data is maintained. Based on the evidence provided, the facility meets this provision. 115.287(d) The facility PAQ indicates the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The agency master PREA Policy section 115.287 was reviewed as supportive documentation. Policy section 115.287(d) states: "***The agency will maintain, review, and collect data as needed from all available incident- based documents including reports, investigation files, and sexual abuse incident reviews. This will be gathered by investigators and the agency PREA coordinator. All files will be retained by the agency PREA coordinator at the main office.***" The policy states that the agency PREA coordinator collects allegation reports, reviews aggregated data, and prepares an annual report. The auditor verified that the final report is posted on the GLC website. All allegation records of sexual abuse are securely maintained. During the onsite audit, the auditor observed client files in locked cabinets in the PREA coordinator's office. The auditor observed the PREA investigation file from 2022, located in a locked cabinet in the PREA coordinator's office. Based on the evidence provided, the facility meets this provision. 115.287(e)(f) These provisions are not applicable, as the agency does not contract for the confinement of its clients, and the Department of Justice has not requested agency data. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard.

	Corrective Action: No corrective action is recommended.

115.288	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA Policy 2. Agency website: https://www.transitionsky.org/ 3. PREA Allegation Summary Report 2020-2022 Interviews: 1. Agency Head 2. PREA coordinator Findings: 115.288(a) The facility PAQ indicates that the agency reviews data collected ad aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including: (a) identifying problem areas: (b) taking corrective action on an ongoing bases; and (c) preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The PAQ includes an annual report from 2020-2022, as supportive documentation. The PREA Policy is provided as supportive documentation. Policy section 115.288(a): **"*The agency will collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.*"** The agency head stated in his interview that the PREA coordinator provides the annual report pursuant to 115.287. The PREA coordinator confirmed during his interview that data is collected for review, and there has been one reported allegation of client sexual abuse in the last 12 months. Based on the evidence provided, the facility meets this provision. 115.288(b) The facility PAQ indicates the annual report includes a comparison of the current year's data and corrective actions with those from prior years. It further states that the annual report provides an assessment of the agency's progress in addressing

sexual abuse. The master PREA policy was provided as supportive documentation. Policy section 115.288(b) states:

"*The 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.*".

The agency head stated during his interview that the agency prepares an annual report, which the PREA coordinator oversees. The auditor verified the facility's annual report posted on the agency website: https://www.transitionsky.org/. The agency PREA coordinator stated during his interview that he is the primary person responsible for preparing the facility's annual report. Based on the evidence provided, the facility meets this provision.

115.288(c)
The facility PAQ indicates the agency's report shall be approved by the agency head and made readily available to the public through its Web site or, if it does not have one, through other means. The GLC master PREA Policy was reviewed as supportive documentation. Policy section 115.288(c) states:

"*(c) The agency's report shall be approved by the agency head and made readily available to the public through its website.*"

The auditor reviewed the agency's website at: https://www.transitionsky.org/; the annual report was observed posted on the site. The agency's website contains a clickable tab to access the 2019 PREA Final audit report. Based on the evidence, the facility meets this provision.

115.288(d)
The facility PAQ indicates when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The master PREA Policy was reviewed as supportive documentation. The policy states in section 115.288(d):

"*(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.*".

The agency head stated during his interview that the PREA coordinator prepared the annual report. He has the ultimate approval of what goes on the website, but he and the PREA coordinator are designees to prepare, and oversee the process. The agency PREA coordinator confirmed that he prepares the annual report, and reviews it with the facility head, and agency CEO.. Information may be redacted, if there is any Personal Identifying Information (PII). Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility meets this standard.

	Corrective Action: No corrective action is recommended.

115.289	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. GLC master PREA policy 2. GLC website: https://www.transitionsky.org/ Interviews: 1. PREA coordinator Findings: 115.289(a), (b), (c) The facility PAQ indicates that the agency ensures incident-based and aggregate data are securely retained. The facility uploaded PREA policy as supportive documentation. The policy states in section 115.289(a) - (c): "***(a) The agency will ensure that data collected pursuant to § 115.287 are securely retained. The agency PREA coordinator will keep paper copies when possible, along with electronic copies on the agency's server.*** ***(b) The agency will make all aggregated sexual abuse data, from facilities under its direct control, readily available to the public at least annually through its website.*** ***(c) Before making aggregated sexual abuse data publicly available, the agency will remove all personal identifiers.***" The PREA coordinator corroborated that he collects and maintains sexual abuse data for creating the annual report; keeping confidential data secure in "under lock and key" in his office. He articulated that he creates the annual report, and ensures personal identifying information (PII) is not included. The agency has no private facilities under its control. The PAQ indicates that aggregated sexual abuse data is made readily available on its website. The auditor verified that the annual report is currently available on the agency website. The link to the agency website is: https://www.transitionsky.org. Based on the evidence provided, the facility meets this provision(s). 115.289(d) The facility PAQ indicates the agency shall maintain sexual abuse data collected

	pursuant to § 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. The facility master PREA Policy was reviewed as supportive documentation. Policy section 115.289(d) states: "***(d) The agency will maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise.***" The auditor reviewed the facility's annual report. The report only provides aggregated data; no 'PII' is included to redact. Therefore, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Emails regarding Notice of PREA audit Interviews: 1. PREA coordinator Onsite facility review: 1. Client room/dorm boards, 2. Client pay phone areas 3. Network room Findings: 115.401(a) The facility PAQ indicates that during the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency ensures that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once. The auditor reviewed the agency website at: **https://www.transitionsky.org/**. The agency website contains live links named 'PREA Report', and 'PREA Data'. The PREA Report link opens to the facility's 2019 Final Audit Report. The PREA Data link opens to the facility's annual data report, prepared by the PREA coordinator. The report covers PREA allegation data from 2020 - 2022. The PREA coordinator stated the facility was audited in 2019; the 2022 audit completes the facility's first audit cycle. Based on the evidence provided, the

	facility meets this provision. 115.401(b) The facility PAQ indicates that during each one-year period starting on August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited. This PREA compliance audit is the third audit of PREA cycle 1 for the facility. The agency has three locations, one of which was audited in 2016, and 2019 respectively. The 2019 PREA compliance audit was conducted at the same facility as the 2016 PREA audit. Based on the evidence provided, the facility meets this provision. 115.401(h) The facility PAQ indicates the auditor shall have access to, and shall observe, all areas of the audited facilities. The PREA coordinator guided the auditor onsite through the all areas of the facility. The PREA coordinator uploaded in the OAS agency policies, procedures, reports, documents, and forms, where such was requested. Those not uploaded, were provided to the auditor onsite. Based on the evidence provided, the facility meets this provision. 115.401(i) The facility PAQ indicates the auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information). The auditor was permitted to request and receive copies of any relevant documents (including electronically stored information). During the onsite facility review, the PREA coordinator provided access to, and explained the functionality of the facility's security video surveillance system, including the system's capacity to retain footage for approximately 30 or more days, and to record isolated video footage onto an external flash drive. Client files are electronically maintained, and staff files are maintained in hard copy form, and were available for the auditor's review. Based on the evidence provided, the facility meets this provision. 115.401(m) The facility PAQ indicates the auditor shall be permitted to conduct private interviews with residents. During the onsite audit, the auditor and her assistant were provided space and time to conduct private interviews with clients on a one-on-one basis. The auditor selected and interviewed a representative sample of 16 clients chosen at random, as well as targeted populations (i.e., LGBTI, disabled), as identified in the PREA Compliance Audit Instrument Interview protocols, retrieved from the National PREA Resource Center website. The number of clients interviewed were based on the population grid outlined in the 2017 PREA Auditor Handbook. Based on the evidence provided, the facility meets this provision. 115.401(n) The facility PAQ indicates that residents shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. Upon entering into an agreement with GLC to conduct a PREA compliance audit, the auditor sent to the facility PREA coordinator, who was the designated point of contact, instructions for the pre-audit phase, to

	begin six weeks prior to the onsite audit. The auditor provided PREA audit notices in English, and Spanish, to be posted in conspicuous locations throughout the facility. The notices contained Auditor contact information for staff, or clients who may wish to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. The auditor advised that such notice be posted on brightly colored paper. A photo of the notices was requested to be sent to the auditor via email. The facility submitted, via email attachments, photos of posted notices, with the corresponding locations. The email was received on the requested date. The notices were printed on brightly colored yellow paper, as requested. During the onsite facility site review, the auditor verified via observation that the notices were posted, as instructed, on brightly colored, yellow paper. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. **Corrective Action:** No corrective action is recommended.

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Agency website, listed as **https://www.transitionsky.org/facilities/grateful-life-center /strong>** **Findings:** **115.403(f)** **The facility PAQ indicates that the agency shall ensure that the auditor's final report is published on the agency's website if it has one, or is otherwise made readily available to the public. The auditor reviewed the GLC website, and verified that the facility 2019 PREA Final audit report is a live link. Based on the evidence provided, the facility meets this provision.**

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

	emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	
	In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
115.213 (a)	**Supervision and monitoring**	
	Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes
115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	na
115.213 (c)	**Supervision and monitoring**	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing	yes

	staffing patterns?	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?	yes
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female inmates.)	na
	Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female inmates.)	na
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches of female residents?	yes
115.215 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility have procedures that enable residents to shower,	yes

	perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	
	Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?	yes
115.215 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?	yes
	If the resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.215 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
115.216 (a)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes

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

	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?	yes
115.217 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of	yes

	force, or coercion, or if the victim did not consent or was unable to consent or refuse?	
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes
115.217 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.217	**Hiring and promotion decisions**	

(f)		
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.217 (h)	**Hiring and promotion decisions**	
	Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.218 (a)	**Upgrades to facilities and technology**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012 or since the last PREA audit, whichever is later.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the	na

	agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes

	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.221 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)	yes
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	na

115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.222 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.222 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).)	yes
115.231 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents’ right to be free from sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with	yes

	residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
115.231 (b)	**Employee training**	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training,	yes

	does the agency provide refresher information on current sexual abuse and sexual harassment policies?	
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes
115.232 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.233 (a)	**Resident education**	
	During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes

	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes
115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.234 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent	yes

	the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	
115.234 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a).)	yes
115.235 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na

	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
	Do medical and mental health care practitioners contracted by	na

	and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
	Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.241 (d)	**Screening for risk of victimization and abusiveness**	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:	yes

	Whether the resident's criminal history is exclusively nonviolent?	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?	yes
115.241 (e)	**Screening for risk of victimization and abusiveness**	
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?	yes
115.241 (f)	**Screening for risk of victimization and abusiveness**	
	Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?	yes

115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident’s risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Incident of sexual abuse?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness?	yes
115.241 (h)	**Screening for risk of victimization and abusiveness**	
	Is it the case that residents are not ever 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?	yes
115.241 (i)	**Screening for risk of victimization and abusiveness**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents?	yes
115.242 (a)	**Use of screening information**	
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?	yes

	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?	yes
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes
115.242 (c)	**Use of screening information**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems?	yes
115.242 (d)	**Use of screening information**	
	Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.242	**Use of screening information**	

(f)		
	Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
115.251 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.251 (b)	**Resident reporting**	

	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.252 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	no
115.252 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve	yes

	with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	
115.252 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: a resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
115.252 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	yes
	If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension is 70 days per 115.252(d)(3)), does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes
115.252 (e)	**Exhaustion of administrative remedies**	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf	yes

	of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	yes
115.252 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.252 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to	yes

	alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	
115.253 (a)	**Resident access to outside confidential support services**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes
115.253 (b)	**Resident access to outside confidential support services**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.253 (c)	**Resident access to outside confidential support services**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.261 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

	information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.261 (b)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.261 (c)	**Staff and agency reporting duties**	
	Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?	yes
	Are medical and mental health practitioners required to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.261 (d)	**Staff and agency reporting duties**	
	If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?	yes
115.261 (e)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators?	yes

115.262 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.263 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes
115.264 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate,	yes

	washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.264 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.265 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes
115.266 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency’s behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes
115.267 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes

	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?	yes
115.267 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency:4. Monitor resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?	yes

	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignment of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.267 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.267 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.271 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/ facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	yes
115.271 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?	yes
115.271 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial	yes

	evidence, including any available physical and DNA evidence and any available electronic monitoring data?	
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.271 (d)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.271 (e)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.271 (g)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.271	**Criminal and administrative agency investigations**	

(h)		
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.271 (i)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?	yes
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes
115.272 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.273 (a)	**Reporting to residents**	
	Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.273 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency	yes

	request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	
115.273 (c)	**Reporting to residents**	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.273 (d)	**Reporting to residents**	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform	yes

	the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	
115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.276 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.276 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.277 (a)	**Corrective action for contractors and volunteers**	

	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.277 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes
115.278 (a)	**Disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process?	yes
115.278 (b)	**Disciplinary sanctions for residents**	
	Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
115.278 (c)	**Disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior?	yes
115.278 (d)	**Disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a	yes

	condition of access to programming and other benefits?	
115.278 (e)	**Disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.278 (f)	**Disciplinary sanctions for residents**	
	For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.278 (g)	**Disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.282 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.282 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?	yes
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information	yes

	about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	
115.282 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na
115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive	na

	information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.286 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes

115.286 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.287 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287	**Data collection**	

(c)		
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.287 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.287 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.287 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	na
115.288 (a)	**Data review for corrective action**	
	Does the agency 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 by: Identifying problem areas?	yes
	Does the agency 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 by: Taking corrective action on an ongoing basis?	yes
	Does the agency 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 by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes

115.288 (b)	**Data review for corrective action**	
	Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse?	yes
115.288 (c)	**Data review for corrective action**	
	Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.288 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes
115.289 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes

115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	yes
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	no
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the	yes

	same manner as if they were communicating with legal counsel?	
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes