PREA AUDIT REPORT ☐ **Interim** ☒ **Final**
COMMUNITY CONFINEMENT FACILITIES

Date of report: 6/22/17

Auditor Information			
Auditor name: Eric Woodford			
Address: PO Box 732 Benicia California 94510-0732			
Email: eiw@comcast.net			
Telephone number: (707) 333-8303			
Date of facility visit: March 6, 2017 to March 8, 2017			
Facility Information			
Facility name: Diversion Residential Facility			
Facility physical address: 3950 N. Nevada Avenue Colorado Springs, CO 80920			
Facility mailing address: *(if different from above)* N/A			
Facility telephone: (719) 473-4460			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	■ Private not for profit		
Facility type:	■ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Sharon Detter			
Number of staff assigned to the facility in the last 12 months: 23			
Designed facility capacity: 135			
Current population of facility: 120			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: Adults 19-67 range			
Name of PREA Compliance Manager: Sue Kuiper	**Title:** Admin support manager/PREA Manager		
Email address: skuiper@comcor.org	**Telephone number:** (719) 473-4460		
Agency Information			
Name of agency: ComCor Inc.			
Governing authority or parent agency: *(if applicable)* N/A			
Physical address: 1355 Kelly Johnson Blvd. Colorado Springs, CO 80920			
Mailing address: *(if different from above)* N/A			
Telephone number: (719) 473-4460			
Agency Chief Executive Officer			
Name: Sharon Detter	**Title:** Executive Director		
Email address: sdetter@comcor.org	**Telephone number:** (719) 473-4460		
Agency-Wide PREA Coordinator			
Name: Anthony Rivers	**Title:** PREA/Quality Assurance Coordinator		
Email address: arivers@comcor.org	**Telephone number:** (719) 955-9851		

AUDIT FINDINGS

NARRATIVE

The Diversion Residential Facility On-Site Audit was scheduled to be conducted from March 6, 2017 to March 8, 2017. On 1/4/17, the Auditor provided the Agency the Pre-Audit Questionnaire (PAQ), Notice of Auditor poster language in English & Spanish, Pre-Audit and On-Site Audit Timeline for review and action by the PREA Coordinator. On 1/24/17, Notices of the Audit were posted in general areas of the facility accessible to both residents and staff. Notices were posted in both English and Spanish. The PREA Coordinator provided auditor with dated photos of Notice locations. On 2-6-17, the PREA Coordinator provided Auditor with the PAQ and supporting documentation. Auditor and PREA Coordinator communicated throughout the Pre-Audit phase to discuss clarification issues with the Pre-Audit Questionnaire and to correct deficiencies identified prior to the On-Site Audit Phase. On 3/1/17, Auditor requested a roster of all Diversion Facility residents and roster of all staff from each of the three shifts scheduled to work during the on-site audit in order to make random selections of staff and residents for interviews. Both rosters were also used by the auditor to make random selections for Personnel, Training and Screening document reviews. The on-site audit phase began on 3/6/17 with the entry briefing, which included the Agency CEO, the Director of Facility Programs, PREA Coordinator, PREA Manager, Program Director for the Diversion Residential Facility, IT Manager, Services Administrator, Contract Administrator, Human Resources Administrator, and a number of staff from administration and facilities administered by this Agency. A summary of the complete Audit process was explained. The Pre-Audit, On-Site Audit, Post-Audit and Corrective Action phases were explained and discussed. Auditor went into detail explaining how an auditor conducts each stage of the On-Site audit process. All questions were answered and the physical plant review began. Total resident population at time of physical plant review was 119 residents, (74 male residents & 45 female residents). Physical Plant Review was conducted as follows:

Posted PREA Information:_
Posters are provided throughout facility and behind each resident room door to include Zero-Tolerance.

- Dayroom – Poster in English and Spanish which provides limits to confidentiality and language which indicates phone calls are not monitored by Agency

Opposite Sex Viewing?_
Facility is PREA compliant. Auditor did not observe any opportunity for opposite sex viewing.

Camera Placement/Blind-spots identified:
Cameras are strategically placed throughout the facility to provide for sexual safety of residents. Video technology and mirrors are in addition to staff interacting with residents and conducting security checks on a 30 to 45-minute basis. The following blind spots were identified:

- Upstairs & downstairs Case Manager offices. All offices have solid doors with no windows available for staff to successfully conduct security or welfare checks when staff is conducting interviews or client business with doors closed.

Announcement: Staff cross-gender announcements observed by auditor How: Knock & announce, “Female/Male Staff”

General Discussion with Staff (Not Interviews): Informal staff interviews indicate staff knows PREA, allegation of sexual abuse, harassment & retaliation response protocols and providing sexual safety for residents.
General Discussion with Residents (Not Interviews): Informal discussion with residents indicates their knowledge of PREA and verify provision of PREA education upon intake and methods for reporting sexual abuse, harassment and retaliation. Residents feel safe in this facility.

Phones:
PREA signage is located near Dayroom phones in English and Spanish

Grievance Process:
During on-site audit review, grievance process had residents obtain grievance forms from Tech Office & turn in written

grievances locked grievance box outside Tech office under the Security Office window to which only Correctional Supervisors and Correctional Director have access to. Grievance forms are available in the Day Room so residents do not need to contact staff to obtain one. This provides ability for residents to submit grievances anonymously. The above information is provided to residents in the PREA Pamphlet.

Showers and Bathrooms:
All resident rooms have separate showers & bathrooms with doors and draw curtains. Showers and bathrooms are PREA compliant and provides privacy for the residents.

Recreation Areas/TV/Multi-Purpose:
1 day-room located in security/Tech office location. PREA signage which provides for limits of confidentiality and monitoring language for contact information on DOC-Tips hotline and Rape Crisis Center contact information for communication for outside Agencies that provide reporting method and advocacy.

Laundry:

- Laundry room located between rooms 6 & 7 & locked at all times
- Camera inside Laundry room with windows on each side
- No hidden areas inside laundry room. 1 laundry for the entire facility
- 1 client allowed in laundry room at a time
- Two cameras inside laundry room and 2 cameras located outside laundry room access door.
- Draw key located in Tech office, signed in and out by both Staff & Client
- Staff escorts client to and from laundry room

COMCOR ADMINISTRATION BUILDING

Administration building is located at 3615 Roberts Road and contains administrative offices, counseling and education classrooms. Administration building characteristics are as follows:

CLASSROOMS:

- 6 classrooms in building, 3 upstairs & 3 downstairs. Instructors release clients for breaks & escort them to bathrooms and outside to smoke
- Zero-tolerance & confidential contact numbers signage in each classroom
- Hallway bathrooms for both upstairs & downstairs locations are monitored by cameras installed in 2015. Both bathrooms are secreted in the corners (alcove); men & women's bathroom doors squared to each other and are in close proximity of each other. Both cameras have views of the corners so no blind spots exist.

THERAPIST OFFICE – 2ND FLOOR:

- At least 8 clinician offices with 2 staff members on floor in offices during business hours at all time (assessment & business support).
- Additional Sexual safety & sex abuse/harassment posters on walls
- After hours clinicians may meet with client one-on-one. Roving security for building makes rounds. Checking doors. Clinician doors usually partially open during session. Insufficient to maintain sexual safety. During 2015 audit, auditor recommended notification of security when after hours session is conducted & have them stand by during session or schedule meeting in residential unit after hours. Agency immediately amended Policy SEC-018 and implemented Auditor's recommendations. Staff practices said policy to this day.

ADMINISTRATIVE OFFICES:

- Clients not allowed in after 5pm & closed to residents for staff safety. Locked & alarmed after staff leave.

WAREHOUSE:

- Blind Spot. Clients are prohibited from entering the warehouse. Staff accesses the warehouse through multiple entrances. There are no cameras in the warehouse and multiple areas are unsupervised.

LITERACY LAB:

- Literacy lab is locked & closed after business hours
- Sexual safety & sex abuse/harassment posters on walls
- Sex safety poster in hallway
- Common use bathrooms in from foyer direct supervision by staff
- Donation closet for clothing located outside literacy lab off hallway. During 2015 audit, auditor recommended protocol added to supervision & monitoring policy to mandate all doors be locked when staff not there to supervise. Agency updated Policy SEC-022 mandating doors to all areas are to be locked when not in use. Staff practices the policy to this day. Only staff accesses the donation closet. Resident access prohibited.
- Vocational Training room is a blind spot. There are no cameras in the outside hall & room has access to the warehouse which has no cameras or supervision. Both entry & exit doors to classroom are closed during classroom sessions with staff having the only keys.

KITCHEN & DINING FACILITY

Kitchen and Dining Facility is located at 3820 Nevada Avenue provides all meals to residents. Large dining hall, supervised by staff and monitored by numerous video cameras. Case Manager's office is through an entry door from the back of the Dining hall. Dining hall characteristics are as follows:

- Dining, service and food preparation areas has numerous cameras & mirrors.
- Zero tolerance & sexual safety counseling posters located on walls of dining hall.
- Food Services Manager & Administrator on site.
- Signage in English & Spanish throughout dining area.
- 2 employee cooks man kitchen during feeding hours.
- 6 residents assist during feeding hours in scullery & cleanup.
- Extra duty staff present when residents are present & during feeding.
- Staff only serves meals.
- Camera located in Kitchen area hallway leading to the rear of the kitchen. It provides view of Food Service Manager office entry, reefer & dry goods warehouse entry. No residents allowed down this hallway.
- Bathrooms located outside Case Manager office & dining room cameras have view of those areas for security.
- Cameras on all 4 corners on outside of Food Service building.
- Case Manager offices for 3808 & 3950 Residential Facilities are located at end of dining hall and can be accessed from the dining room through an internal entry door. Internal entry door at end of dining hall is secured & multiple staff in office during office hours. (2) Two cameras are strategically placed with view of outside entry door, back of building and parking lot. Agency added 180-degree camera inside the Case Manager offices for safety and security. Currently, after hours, security staff is notified when staff working alone in office. Recommendation for written directive and training for Case Management staff that mandates - before 10am and after 4pm, should Case Managers decide to see residents in the Case Management office, there needs to be an additional staff member available during the resident's visit. Otherwise Case Managers can see residents at the facility.

Recreation Yard

- One main central area for recreation, additional area within the main central area located outside main office building which provides for picnic tables and seating area.
- No bathrooms located off the recreation area as all residents have access to bathrooms in their rooms.
- Numerous cameras cover the recreation areas and back side of Diversion Facility housing buildings. Auditor observed facility camera views through Tech Office and management staff computers. The recreation area is covered with no blind spots or hidden areas.

Storage Room/Computer & Video Server Room:

This area is located in Boiler Room across from the Compliance Coordinator's Office. Access is covered by 1 camera which

monitors entry and egress. This room requires a Draw-Key which is located in the Security Office.

Following the physical plant review, interviews comprised of a sampling of 20 random residents of varying characteristics and sampling of 15 random staff selected from each shift was conducted. On 3/7/17 Auditor completed the resident & staff interviews, then conducted 19 Specialized Staff interviews and Agency management interviews. During resident interviews, staff mental health practitioners were available for emotional support if needed. No referrals for advocacy occurred during the interview process. Following the interviews, the auditor conducted a review of 21 Personnel files, 20 screening records, 7 investigative files and 22 training records. Following the physical plant observation, an exit briefing was conducted and attended by ComCor Inc. leadership and staff. General observations by auditor was discussed with attendees. On-Site Audit was then concluded at the end of the exit briefing. During the Post-Audit phase, PREA Coordinator and Auditor collaborated on issues discovered during the On-Site Audit review, interviews and document review. Agency conducted a number of corrections prior to auditor issuing the Interim Report on 4/6/17.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Diversion facility (3950) houses a co-ed population for ComCor, Inc. consisting of primarily Diversion, Bureau of Prison, and Intensive Residential Treatment program populations. The facility consists of the three buildings. The main office is the central hub of client and staff operations which is connected to room's #17U, 17L and 18. The main office is made up of two staff offices, a staff restroom, the client day room/common area and a basement where case management offices are located. The second building contains rooms 1-12, a furnace and boiler access room, a laundry room and a storage room underneath room # 12. The third building is a duplex apartment building which contains rooms 20-25 and has furnace and boiler access rooms.

The rooms for the 3950 facility can accommodate the following number of clients:

Room 1= 4 Clients	Room 2= 4 Clients	Room 2A= 3 Clients
Room 3= 4 Clients	Room 4= 4 Clients	Room 4A= 3 Clients
Room 5= 4 Clients	Room 6= 4 Clients	Room 7= 4 Clients
Room 8= 4 Clients	Room 8A= 5 Clients	Room 9= 4 Clients
Room 10= 4 Clients	Room 10A= 5 Clients	Room 11= 4 Clients
Room 12= 4 Clients	Room 17U= 8 Clients	Room 17L= 10 Clients
Room 18= 5 Clients	Room 20*-20A= 12 Clients	Room 21*-21A*= 12 Clients
Room 22= 6 Clients	Room 23=6 Clients	Room 24=6 Clients
Room 25= 6 Clients		

The Diversion Facility has the capacity to house 135 clients. Female clients are housed in 2 separate housing units across from the Tech Office/Day Room and in a 2-story building at the rear of the facility. Female clients are currently housed in rooms 1, 2 and duplex building rooms 20 to 25. Housing units can house anywhere from 3 up to 12 clients depending on the individual unit. There is a unit for handicapped clients which house up to 6 male clients. High-resolution cameras are placed throughout the facility to include alleyways and rear areas of the housing units. A dedicated camera is views the front of the female housing units. Camera views overlap to provide full viewing access for staff. Intake and screening is conducted in the front office where the day room is also located. The dining facility is a short walk from the residential facility. Clients assist with cleaning tables, washing dishes and serving food. 3 dedicated staff members provide security while residents are in the dining hall facility. Literacy lab, group/individual and mental health counseling is conducted in the 2-story client services building, which is located ½ mile from the facility. The client services building conducts 1 counseling class during the day and can conduct up to 4 sessions in the evening. Staff are always present in the building on both floors at all times. 3 dedicated staff conduct security sweeps while residents are in session. Residents are escorted to and from the bathrooms one at a time, when bathroom breaks are requested.

SUMMARY OF AUDIT FINDINGS

On March 6, 2017 through March 8, 2017, a PREA Audit physical plant review was conducted at ComCor Inc. Diversion Residential Facility in Colorado Springs, Colorado. The summary of Interim and Final audit result findings are as followings:

INTERIM AUDIT SUMMARY REPORT	FINAL AUDIT SUMMARY REPORT
Number of Standards exceeded: **2**	Number of Standards exceeded: **3**
Number of Standards met: **27**	Number of Standards met: **34**
Number of Standards not met: **8**	Number of Standards not met: **0**
Number of Standards not applicable: **2**	Number of Standards not applicable: **2**

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.211(a) – POLICY PREA-010 IDENTIFIES AGENCY ZERO TOLERANCE POLICY TOWARDS SEXUAL ABUSE & SEXUAL HARASSMENT. POLICY PREA-009 INCLUDES DEFINITIONS OF PROHIBITED BEHAVIORS, ZERO TOLERANCE POLICY NARRATIVE & IMPLEMENTATION NARRATIVE REGARDING THE AGENCY'S STRATEGIES & APPROACH TO PREVENTING, DETECTING AND RESPONDING TO SEXUAL ABUSE/HARASSMENT. POLICY PREA-014 MANDATES SANCTIONS FOR PROHIBITED BEHAVIORS.

115.211(b) - PREA COORDINATOR INTERVIEWED & STATES HE HAS SUFFICIENT TIME & AUTHORITY TO DEVELOP, IMPLEMENT, AND OVERSEE AGENCY EFFORTS TOWARDS PREA COMPLIANCE. THE PREA COORDINATOR POSITION IS IDENTIFIED AS AN UPPER LEVEL AGENCY WIDE POSITION IN ORGANIZATIONAL CHART 2ND LEVEL DOWN FROM THE CEO.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.211

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

■ Not Applicable

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.

STANDARDS 115.212(a) THROUGH 115.212(c) DO NOT APPLY TO COMCOR INC. AS AGENCY HAS NOT ENTERED IN TO ANY CONTRACTS FOR THE CONFINEMENT OF CLIENTS

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.213(a) - AUDITOR WITH COMPLIANT 3950 STAFFING PLAN SPECIFIC TO THE DIVERSION FACILITY. THE PLAN IDENTIFIES THE DIVERSION FACILITY CHARACTERISTICS, POPULATION, PHYSICAL PLANT, BLIND SPOTS, CORRECTIVE ACTIONS, ELECTRONIC MONITORING, STAFFING PER SHIFT, SUBSTANTIATED AND UNSUBSTANTIATED SEXUAL ABUSE INCIDENTS AND PROGRAMMING. STAFFING PLAN INDICATES THERE HAVE BEEN NO STAFFING PLAN DEVIATIONS FOR CALENDAR YEAR 2016. POLICY SEC-011 NARRATIVE IS COMPLIANT WITH STANDARD 115.213(a) AND CONTAINS ALL 4 CRITERIA AS OUTLINED IN STANDARD. INTERVIEW WITH DIRECTOR & PREA COORDINATOR INDICATES AGENCY ENSURES FACILITY MAINTAINS ADEQUATE STAFF TO PROVIDE COVERAGE PER EACH SHIFT TO ACCOMMODATE FOR STAFF & CLIENT SAFETY. THE FACILITY HOUSES BOTH MALE AND FEMALE RESIDENTS. AUDITOR'S REVIEW OF STAFFING PLAN FOUND IT CONSIDERS THE PHYSICAL LAYOUT OF THE TRANSITION FACILITY, COMPOSITION OF RESIDENT POPULATION, BLIND SPOTS WITHIN THE FACILITY, CORRECTIVE ACTIONS TAKEN, STAFFING REQUIREMENTS AND VIDEO MONITORING CAPABILITIES.

115.213(b) - POLICY PROVIDES FOR JUSTIFICATION & DOCUMENTATION FOR ALL DEVIATIONS OF THE STAFFING PLAN. THERE HAVE BEEN NO DEVIATIONS FROM STAFFING PLAN OVER THE PAST 12 MONTHS.

115.213(c) - ANNUAL STAFFING PLAN REVIEW PROVIDED. STAFFING PLAN IS SPECIFIC TO DIVERSION FACILITY. PLAN INCLUDES FACILITY POPULATION CHARACTERISTICS, MAXIMUM BED SPACE FOR THE FACILITY, STAFFING PATTERNS, BLIND SPOTS WITHIN THE FACILITY TO INCLUDE ACTIONS TAKEN TO CORRECT THE BLIND SPOTS, STAFFING REQUIREMENTS TO INCLUDE STATEMENT THAT NO DEVIATIONS FROM THE STAFFING PLAN HAS OCCURRED OVER THE PAST 12 MONTHS. CONSIDERATIONS OF SUBSTANTIATED AND UNSUBSTANTIATED INCIDENTS OF SEXUAL ABUSE AND OTHER RELEVANT FACTORS ARE PROVIDED WITH A RESPONSE TO RECOMMENDED CORRECTIONAL ACTIONS TAKEN BASED UPON THAT DATA.
PREA COORDINATOR CITES POLICY SEC-011 PAGE #4 WHICH STATES THAT NO LESS THAN ONCE A YEAR, THE HR DIRECTOR, FACILITY AND PROGRAM MANAGERS ANNUALLY REVIEW STAFFING REQUIREMENTS.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.213

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.215(a) - POLICY SEC-013 PROHIBITS CROSS GENDER STRIP OR VISUAL BODY CAVITY SEARCHES OF RESIDENTS. NO CROSS GENDER STRIP OF VISUAL BODY CAVITY SEARCHES OF RESIDENTS IN PAST 12 MONTHS. INTERVIEWS OF RANDOM NON-MEDICAL STAFF ALL RESPOND CROSS GENDER SEARCHES ARE AGAINST COMCOR INC. POLICY ABSENT EXIGENT CIRCUMSTANCES WHERE SAME SEX STAFF CONDUCTS THE SEARCH. MEDICAL STAFF CONDUCTS BODY CAVITY SEARCHES.

115.215(b) - POLICY SEC-013 DICTATES SAME SEX STAFF CONDUCTS PAT DOWN SEARCHES ON RESIDENTS. IF CROSS GENDER STAFF INVOLVED, NO CONTACT SEARCH IS CONDUCTED. ALL PAT-DOWN SEARCHES ARE DOCUMENTED IN THE COMCOR AUTOMATED TRACKING SYSTEM (CATS) DATABASE WHETHER CONTACT OR NO CONTACT. INTERVIEW WITH RANDOM STAFF & RESIDENTS VERIFY STAFF CONDUCTS SEARCHES IN ACCORDANCE WITH POLICY. COMCOR MANDATES BOTH MALE & FEMALE STAFF ARE ASSIGNED FOR EVERY SHIFT. DIVERSION FACILITY IS A CO-ED FACILITY.

115.215(c) - PER POLICY SEC-013, ALL PAT-DOWN SEARCHES ARE DOCUMENTED IN THE "CATS" DATABASE WHETHER CONTACT OR NO CONTACT SEARCHES ARE CONDUCTED.

115.215(d) - POLICY PREA-008 INCLUDES STANDARD NARRATIVE. POLICY STATES STAFF OF OPPOSITE AND SAME GENDER ANNOUNCE PRESENCE WHEN ENTERING AREA WHERE RESIDENTS ARE SHOWERING OR IN SOME FORM OF UNDRESS. INTERVIEW OF RANDOM STAFF & RESIDENTS INDICATE FACILITY POLICY MANDATES RESIDENTS CAN ONLY CHANGE CLOTHING IN THE BATHROOM OR SHOWER LOCATED WITHIN EACH RESIDENT ROOM. BOTH ROOMS HAVE DOORS ATTACHED FOR PRIVACY.

115.215(e) - POLICY SEC-013 PROHIBITS SEARCH OF TRANSGENDER & INTERSEX RESIDENTS FOR THE SOLE PURPOSE OF DETERMINING THEIR GENITAL STATUS. NO TRANSGENDER OR INTERSEX RESIDENTS HOUSED AT FACILITY AT THIS TIME. INTERVIEW WITH RANDAM STAFF VALIDATES POLICY NARRATIVE AND PRACTICE.

115.215(f) - INTERVIEW WITH RANDOM STAFF INDICATES ALL HAVE BEEN TRAINED IN CROSS-GENDER PAT-DOWN SEARCHES & SEARCHES OF TRANSGENDER & INTERSEX RESIDENTS IN A PROFESSIONAL AND RESPECTFUL MANNER, CONSISTENT WITH SECURITY NEEDS. STAFF INDICATES CROSS-GENDER PAT DOWN SEARCHES ARE CONDUCTED AS NO-CONTACT SEARCHES WHEN EITHER GENDER OF STAFF INVOLVED EXCEPT IN EXIGENT CIRCUMSTANCES. IN THE CASE OF EXIGENT CIRCUMSTANCES, POLICY DICTATES STAFF OF SAME GENDER WILL CONDUCT SEARCHES. REGARDING TRANSGENDER & INTERSEX RESIDENTS, POLICY DICTATES GENDER OF STAFF CONDUCTING SEARCHES WILL BE CHOSEN BY MANAGEMENT AFTER RESIDENT INDICATES WHICH GENDER THEY PREFER. AGENCY IDENTIFIED 25 STAFF ASSIGNED TO FACILITY AND INDICATES 100% OF STAFF HAVE BEEN TRAINED IN CONDUCTING CROSS-GENDER PAT-DOWN SEARCHES AND SEARCHES OF TRANSGENDER AND INTERSEX RESIDENTS IN A PROFESSIONAL MANNER. REVIEW OF TRAINING CURRICULA VERIFIES TYPE OF TRAINING WHICH MEETS STANDARD PROVISION 115.215(f).

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.215

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.216(a) - POLICY MGT 007 MANDATES PROCEDURES TO PROVIDE DISABLED RESIDENTS EQUAL OPPORTUNITY TO PARTICIPATE IN ALL ASPECTS OF AGENCY'S EFFORTS TO RESPOND TO SEX ABUSE/HARASSMENT. AGENCY POSSESSES A VOIANCE CONTRACT WHICH PROVIDES FOR LANGUAGE INTERPRETERS AND PREA EDUCATIONAL BROCURES IN ENGLISH & SPANISH WHICH EDUCATES RESIDENTS ON AGENCY'S ZERO TOLERANCE POLICY, RIGHT TO BE FREE OF SEXUAL ABUSE, HARASSMENT AND RETALIATION AND METHODS OF REPORTING ALLEGATIONS OF SEXUAL MISCONDUCT. RANDOM STAFF TRAINING RECORDS INCLUDING CONTRACTOR TRAINING RECORDS ALL POSSESS STAFF ACKNOWLEDGEMENT TO PROVIDE EQUAL OPPORTUNITY FOR CLIENTS TO PARTICIPATE IN ALL ASPECTS OF PREVENTION, DETECTION & RESPONSE TO SEX ABUSE & SEX HARASSMENT. TOUR OBSERVATION INDICATES PREA NOTICE POSTINGS IN BOTH ENGLISH & SPANISH IN VOCATIONAL COMPUTER LAB, COUNSELING CLASSROOMS AND DINING HALL. PREA NOTICES ARE POSTED TO THE INSIDE OF ENTRY DOORS OF EVERY HOUSING UNIT AND THE DAY ROOM. BROCHURES IN BOTH ENGLISH & SPANISH WERE VERIFIED. REVIEW OF VOIANCE CONTRACT WAS CONDUCTED AND IS PREA COMPLIANT. INTERVIEW WITH AGENCY HEAD VERIFIES COMPLIANCE WITH THIS STANDARD PROVISION. STAFF SPECIFIC ZERO TOLERANCE & PREA POSTERS ARE PROVIDED IN ALL AREAS FREQUENTED BY BOTH STAFF AND RESIDENTS.

115.216(b) – TWO RESIDENTS IDENTIFIED AS LIMITED COGNITIVE ABILITIES WERE INTERVIEWED. THEY INDICATED STAFF ASSISTS THEM IN EVERY WAY DURING THEIR STAY. STAFF ENSURES THEY ARE AWARE OF AGENCY POLICIES AS THEY RELATE TO SEXUAL SAFETY. POLICIES MGT-007 & PREA-001 OUTLINES REQUIREMENTS TO PROVIDE RESIDENTS WITH ZERO TOLERANCE POLICY, RESIDENT RIGHT TO BE FREE FROM SEXUAL ABUSE/SEXUAL HARASSMENT/RETALIATION AND SEXUAL ABUSE REPORTING INFORMATION. DATA IS TO BE PROVIDED TO ALL RESIDENTS WITHIN 12 HOURS OF ADMISSION TO THE FACILITY. AGENCY PROVIDES INTERPRETERS VIA VOIANCE CONTRACT WHICH WAS REVIEWED DURING AUDIT TOUR. INTERVIEW WITH RESIDENT WHO IS IDENTIFIED AS DISABLED, INDICATED CASE MANAGERS WILL READ INFORMATION TO YOU IF YOU CANNOT READ OR DISCUSS WITH YOU IF YOU DO NOT UNDERSTAND THE INFORMATION THAT IS PROVIDED.

115.216(c) - POLICY PREA-001 PROHIBITS USE OF RESIDENT INTERPRETERS ABSENT EXIGENT CIRCUMSTANCES AND, IN THOSE INSTANCES, THE ACT IS DOCUMENTED. IN THE PAST 12 MONTHS THERE HAVE BEEN NO INSTANCES WHERE RESIDENT INTERPRETERS WERE UTILIZED. INTERVIEW WITH RANDOM SAMPLE OF 15 STAFF INDICATES THEIR KNOWLEDGE AND EDUCATION AS IT RELATES TO THE PROHIBITION OF THE USE OF RESIDENT INTERPRETERS. THEY KNOW THAT EITHER STAFF OR CONTRACT INTERPRETERS ARE UTILIZED IN THOSE SITUTATIONS.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.216

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.217(a) – POLICY PER-004 PROHIBITS HIRING OR PROMOTING ANYONE WHO MAY HAVE CONTACT WITH RESIDENTS OR ENLISTING THE SERVICES OF ANY CONTRACT WHO MAY HAVE CONTACT WITH RESIDENTS WHO HAS ENGAGED IN SEXUAL ABUSE IN ANY CONFINEMENT SETTING, CONVICTED OR ATTEMPTING TO ENGAGE IN SEXUAL ACTIVITY IN THE COMMUNITY THROUGH USE OF FORCE OR FEAR OR CIVILLY OR ADMINISTRATIVELY ADJUDICATED TO HAVE ENGAGED IN THE ACTIVITY DESCRIBED ABOVE.

115.217(b) – AGENCY POLICY PER-004 REQUIRES CONSIDERATION OF ANY INCIDENTS OF SEXUAL HARASSMENT IN DETERMINING WHETHER TO HIRE OR PROMOTE ANYONE, INCLUDING CONTRACTORS, WHO MAY HAVE CONTACT WITH RESIDENTS. INTERVIEW WITH HUMAN RESOURCES ADMINISTRATOR DETERMINED AGENCY CONSIDERS ANY INCIDENTS OF SEXUAL HARASSMENT IN DETERMINING WHETHER TO HIRE OR PROMOTE ANYONE OR ENLIST THE SERVICES OF ANY CONTRACTOR WHO MAY HAVE CONTACT WITH RESIDENTS. ADMINISTRATOR STATED SHOULD ANY SEXUAL HARASSMENT BEHAVIOR BE DISCOVERED, THERE IS NO DETERMINATION AS TO WHETHER OR NOT THAT PERSON IS HIRED – THEY FAIL THE BACKGROUND IMMEDIATELY AND ARE NOT CONSIDERED FOR EMPLOYMENT. SAME GOES FOR CONTRACTORS, VOLUNTEERS AND TEMPORARY EMPLOYEES.

115.217(c) – POLICY PER-008 MANDATES BEFORE HIRING AN APPLICANT, CONTRACTOR OR VOLUNTEER, A CCIC/NCIC CRIMINAL HISTORY CHECK IS COMPLETED BY FORWARDING THE APPROPRIATE INFORMATION TO DOJ & DCJ (FOR THOSE WORKING WITH FEDERAL RESIDENTS). THE APPLICANT OR VOLUNTEER CAN BE HIRED WHEN THE HISTORY CHECK INFORMATION IS RECEIVED BACK FROM NCIC WITH AN INDICATION OF NO CRIMINAL HISTORY. 13 PEOPLE HAVE BEEN HIRED OVER THE PAST 12 MONTHS FOR THIS FACILITY. REVIEW OF 20 RANDOMLY SELECTED PERSONNEL FILES INDICATE ALL HAVE COMPLETED BACKGROUND CHECKS THROUGH THE USE OF CCIC/CBI/FBI & BOP CHECKS. INTERVIEW WITH HR STAFF INDICATE ALL BACKGROUND CHECKS FOR APPLICANTS HAVE BEEN COMPLETED.

115.217(d) – POLICY PER-008 MANDATES COMCOR, INC., WILL CONDUCT A CRIMINAL RECORD CHECK TO INCLUDE A BACKGROUND INVESTIGATION AND AN NCIC (NATIONAL CRIMINAL INFORMATION CENTER) CRIMINAL HISTORY CHECK FOR "WANTS" AND WARRANTS BEFORE AN APPLICANT IS HIRED, OR CONTRACTORS WHO WILL BE HAVING CONTACT WITH CLIENTS, OR A VOLUNTEER BEGINS SERVICE. REVIEW OF THE CONTRACTOR PERSONNEL FILES INDICATES A CCIC CLEARANCE. THIS CLEARANCE PROVIDES FOR AN NCIC CLEARANCE ALSO, MEETING THE REQUIREMENT THAT BACKGROUND CHECK MEETS BOTH STATE AND NATIONAL CLEARANCE FOR AN INITIAL HIRE. AFTER THE FINGERPRINT CARD IS SENT TO CBI/FBI, A SECOND CLEARANCE IS RECEIVED. OVER THE PAST 12 MONTHS, 2 CONTRACTORS HAVE BEEN HIRED.

115.217(e) – POLICY-008 MANDATES BACKGROUND CHECKS BE CONDUCTED AT LEAST EVERY 5 YEARS OF CURRENT EMPLOYEES & CONTRACTORS. INTERVIEW WITH HR ADMINISTRATOR INDICATES BACKGROUND CHECKS OF STAFF AND CONTRACTORS IS CONDUCTED EVERY 5 YEARS AS A RENEWAL. RANDOM SAMPLE OF 20 STAFF AND CONTRACTOR PERSONNEL FILES INDICATED THAT 8 OF THE 20 PERSONNEL WERE RECENTLY HIRED WITHIN THE PAST 12 MONTHS. ALL REMAINING 12 STAFF HAD A BACKGROUND RENEWAL CHECK CONDUCTED WITHIN 5 YEARS OF THEIR HIRE DATE.

115.217(f) – POLICIES PER-004 MANDATES ALL APPLICANTS FOR EMPLOYMENT AND CURRENT EMPLOYEES FOR PROMOTION ARE QUESTIONED DIRECTLY EITHER IN AN INTERVIEW OR ON APPLICATIONS ABOUT PREVIOUS SEX ABUSE MISCONDUCT AS IDENTIFIED IN STANDARD 115.217(a) PER INTERVIEW WITH HR ADMINISTRATOR. THESE QUESTIONS & RESPONSES ARE NOT DOCUMENTED. REVIEW OF SOME ADDITIONAL PERSONNEL FILES INDICATE THE QUESTIONS OF PREVIOUS MISCONDUCT IS NOT INCLUDED IN THE RENEWAL APPLICATION FOR STAFF WHO RESIGN FROM COMCOR INC THEN AT A LATER DATE, RETURN TO COMCOR INC AS A RE-HIRE. POLICY ALSO MANDATES AN AFFIRMATIVE DUTY TO DISCLOSE SUCH MISCONDUCT. INTERVIEW WITH HR ADMINISTRATOR AND REVIEW OF HIRING PACKET IN PERSONNEL FILES VERIFY COMPLIANCE WITH THIS STANDARD FOR APPLICANTS.

115.217(g) – POLICY PER-004 MANDATES STATE MATERIAL OMISSIONS REGARDING SEXUAL ABUSE/SEXUAL HARASSMENT MISCONDUCT, OR THE PROVISION OF MATERIALLY FALSE INFORMATION, ARE GROUNDS FOR TERMINATION.

115.217(h) – POLICY PER-008 STATES "*Unless prohibited by law, ComCor 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*". INTERVIEW WITH HR ADMINISTRATOR INDICATES INFORMATION IS RELEASED UPON RECIEPT OF RELEASE OF INFORMATION SIGNED BY FORMER EMPLOYEE. HR SEEKS TO OBTAIN A RELEASE OF INFORMATION FROM EMPLOYEE WHO RESIGNS OR IS TERMINATED SHOULD HE/SHE NEED A REFERENCE FOR EMPLOYMENT FROM ANOTHER AGENCY.

RECOMMENDATION: Require Human Resources to maintain work start date for all contractors and volunteers.

AUDITOR HAS DETERMINED THAT AGENCY IS NOT INCOMPLIANCE WITH STANDARD PROVISION 115.217(f)

CORRECTIVE ACTION:
AGENCY TO IMPLEMENT AND PROVIDE VERIFICATION OF THE FOLLOWING CORRECTIVE ACTIONS:

1. AGENCY TO CREATE WRITTEN DIRECTIVE FOR HUMAN RESOURCES TO INCLUDE QUESTIONS REGARDING SEXUAL MISCONDUCT IN RENEWAL APPLICATIONS FOR RE-HIRES

2. AGENCY TO PROVIDE WRITTEN QUESTIONNAIRE TO APPLICANTS REGARDING SEXUAL MISCONDUCT HISTORY PRIOR TO OR DURING PROMOTIONAL INTERVIEWS

CORRECTIVE ACTION TO BE COMPLETED NO LATER THAN 10/5/17

CORRECTIVE ACTION COMPLETION 7/6/17:
AGENCY HAS TAKEN THE FOLLOWING CORRECTIVE ACTION MEASURES:

1. ON 7/6/17, AGENCY PROVIDED AUDITOR WITH WRITTEN DIRECTIVE FOR HUMAN RESOURCES TO INCLUDE QUESTIONS REGARDING SEXUAL MISCONDUCT IN RENEWAL APPLICATIONS FOR RE-HIRES. THERE HAVE BEEN NO RE-HIRES SINCE THE ON-SITE AUDIT. TRAINING LOG WAS ALSO PROVIDED WHICH VERIFIES ALL 3 HUMAN RESOURCES STAFF ASSIGNED TO EMPLOYMENT APPLICATIONS, PROMOTIONS AND REHIRES HAVE BEEN TRAINED ON THE NEW DIRECTIVE.
2. AGENCY PROVIDED WRITTEN QUESTIONNAIRE TO APPLICANTS REGARDING SEXUAL MISCONDUCT HISTORY TO BE COMPLETED PRIOR TO PROMOTIONAL INTERVIEWS. THIS FORM WAS USED DURING A RECENT PROMOTIONAL INTERVIEW PROCESS.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.217

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.218(a) – AGENCY INDICATES THERE HAS BEEN NO ACQUISITION FOR ANY NEW FACIITIES OR SUBSTANTIAL EXPANSIONS OR MODIFICATIONS OF EXISITING FACILITIES SINCE LAST PREA AUDIT. INTERVIEW WITH AGENCY HEAD AND DIRECTOR INDICATES NO NEW FACILITY ACQUIRED BY AGENCY SINCE LAST PREA AUDIT JULY 2014. SHOULD AGENCY DECIDE TO DESIGN OR ACQUIRE A NEW FACILITY OR MODIFY EXISTING FACILITY, AGENCY CONSIDERS THE LAYOUT FO THE FACILITY, POPULATION IT WILL SERVE, GENDER OF RESIDENTS, DESIGN & PLACEMENT OF VIDEO TECHNOLOGY, STAFFING OF ALL SHIFTS, SHIFT TENURE & MIX OF EXPERIENCE & RESIDENT

CLASSIFICATION.

115.218(b) – AGENCY INDICATES THERE HAS BEEN INSTALLATION OF VIDEO TECHNOLOGY SINCE LAST PREA AUDIT IN 2015. DIVERSION FACILITY VIDEO SYSTEM WAS UPGRADED TO A DEDICATED SYSTEM AND ADDITIONAL CAMERAS WERE ADDED FOR RESIDENT AND STAFF SAFETY. DURING AUDIT TOUR, AUDITOR REVIEWED NEWLY INSTALLED VIDEO CAMERAS IN THE DINING HALL, DIVERSION GENERAL RECREATION YARD AND STAIRS TO GATED (WITH RAZOR WIRE) AREA LEADING TO STOREROOM UNDERNEATH HOUSING BUILDING. AUDITOR VIEWED CAMERA PLACEMENT AND VIDEO FEEDS FROM ALL CAMERAS VIA THE TECH OFFICE AND MANAGER OFFICE COMPUTERS. CAMERA SYSTEM IS VIEWED ON CATS SYSTEM ALSO. THIS TECHNOLOGY IS UTILIZED TO DETERMINE CAMERA PLACEMENT FOR SURVEILLANCE & MONITORING. THERE IS ENHANCED VIDEO TECHNOLOGY INSIDE THE CASE MANAGERS' OFFICE FACILITY ADJACENT TO KITCHEN DINING HALL, WHICH PROVIDES VIEWING OF ALL COMING AND GOING INSIDE & OUTSIDE THE OFFICE. RECOMMENDATION FOR WRITTEN DIRECTIVE AND TRAINING FOR CASE MANAGEMENT STAFF MANDATING BEFORE 10AM AND AFTER 4PM, SHOULD CASE MANAGERS DECIDE TO SEE RESIDENTS IN THE CASE MANAGEMENT OFFICE, THERE NEEDS TO BE AN ADDITIONAL STAFF MEMBER AVAILABLE DURING THE RESIDENT'S VISIT. OTHERWISE CASE MANAGERS CAN SEE RESIDENTS AT THE FACILITY. THE FOLLOWING BLIND SPOTS WERE OBSERVED BY AUDITOR DURING ON-SITE REVIEW THAT WAS MISSED IN THE VIDEO MONITORING ASSESSMENT BY AGENCY:

1. ADMINISTRATION BUILDING 1ST FLOOR MAIN WAREHOUSE AREA
2. ADMINISTRATION BUILDING 2ND FLOOR MENTAL HEALTH OFFICES WHEN ONE STAFF PRESENT
3. ADMINISTRATION BUILDING 1ST FLOOR VOC TRAINING ROOM
4. DIVERSION FACILITY CASE MANAGERS OFFICES HAVE SOLID DOORS & MANAGERS CONDUCT BUSINESS WITH RESIDENTS WITH DOORS CLOSED FOR CONFIDENTIALITY

AUDITOR HAS DETERMINED THAT STANDARD PROVISION 115.218(b) IS NON-COMPLIANT

CORRECTIVE ACTION:

AGENCY TO IMPLEMENT AND PROVIDE VERIFICATION OF BLIND SPOT CORRECTIVE ACTION FOR THE FOLLOWING AREAS:

1. ADMINISTRATION BUILDING 1ST FLOOR MAIN WAREHOUSE AREA
2. ADMINISTRATION BUILDING 2ND FLOOR MENTAL HEALTH OFFICES WHEN ONE STAFF PRESENT
3. ADMINISTRATION BUILDING 1ST FLOOR VOC TRAINING ROOM
4. DIVERSION FACILITY CASE MANAGERS OFFICES HAVE SOLID DOORS & MANAGERS CONDUCT BUSINESS WITH RESIDENTS WITH DOORS CLOSED FOR CONFIDENTIALITY

CORRECTIVE ACTION TO BE COMPLETED NO LATER THAN 10/5/17

CORRECTIVE ACTION COMPLETION 6/14/17:

AGENCY HAS TAKEN THE FOLLOWING CORRECTIVE ACTION MEASURES:

1. ADMINISTRATION BUILDING 1ST FLOOR MAIN WAREHOUSE AREA - AGENCY HAS INSTALLED A 360 DEGREE CAMERA WHICH VIEWS THE COMPLETE WAREHOUSE AREA. AGENCY PROVIDED AUDITOR WITH SCREEN SHOTS OF CAMERA VIEWS.
2. ON 5/6/17, AGENCY PROVIDED AUDITOR WITH CASE MANAGEMENT DIRECTIVE WHICH PROHIBITS CASE MANAGERS AND MENTAL HEALTH TREATMENT PROVIDERS TO MEET ONE-ON-ONE WITH CLIENTS IN THEIR OFFICES BEFORE 10AM OR AFTER 4PM. IF THERE IS A NEED TO MEET ONE-ON-ONE WITH CLIENTS DURING THOSE TIMES, THERE NEEDS TO BE AND ADDITIONAL STAFF MEMBER AVAILABLE DURING THE CLIENT'S VISIT. OTHERWISE CASE MANAGERS AND MENTAL HEALTH TREATMENT PROVIDERS ARE MANDATED TO MEET WITH CLIENTS IN THE FACILITY TECH OFFICE WHERE ADDITIONAL STAFF ARE AVAILABLE. AGENCY

PROVIDED A TRAINING REPORT WHICH VERIFIES CASE MANAGERS AND MENTAL HEALTH TREATMENT PROVIDERS HAVE BEEN TRAINED ON THE NEW DIRECTIVES.

3. AGENCY CREATED A VOCATIONAL CLASSROOM DIRECTIVE WHICH DIRECTS ALL STAFF TO MAINTAIN DOORS TO THE VOCATIONAL CLASSROOM TO REMAIN OPEN DURING REGULAR BUSINESS HOURS. THE DIRECTIVE MANDATES STAFF TO CHECK TO ENSURE CLASSROOM IS NOT OCCUPIED BY STAFF OR CLIENTS HOURLY. SECURITY STAFF MUST CHECK THIS ROOM BEFORE ALARMING THE SECURITY ALARM WHEN THE VOCATIONAL DEPARTMENT CLOSES. AGENCY PROVIDED AUDITOR WITH TRAINING REPORT WHICH VERIFIES BOTH ASSIGNED VOCATIONAL STAFF HAVE BEEN TRAINED ON THE DIRECTIVE.
4. ON 6/14/17, AGENCY PROVIDED AUDITOR WITH CASE MANAGEMENT OFFICE DOOR RE-CONSTRUCTION. EACH DIVERSION FACILITY CASE MANAGER DOOR (3 UPSTAIRS & 5 DOWNSTAIRS) HAVE BEEN REFITTED WITH A WINDOW WHICH ELIMINATES THE BLIND SPOT CREATED WHEN STAFF CLOSE A SOLID DOOR FOR CONFIDENTIAL BRIEFINGS WITH RESIDENTS.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.218

Standard 115.221 Evidence protocol and forensic medical examinations

■ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.221(a) – POLICY PREA-007 PROVIDES SPECIFIC PROTOCOL FOR OBTAINING USABLE PHYSICAL EVIDENCE FOR BOTH ADMINISTRATIVE AND CRIMINAL INVESTIGATIONS OF SEXUAL ABUSE. INTERVIEW OF RANDOM STAFF VERIFY TRAINING THEY HAVE RECEIVED TO SECURE THE SCENE, SEPARATE VICTIM & PERPETRATOR, PLACE THEM WITH STAFF MEMBER TO ENSURE NO PHYSICAL EVIDENCE CAN BE DESTROYED SUCH AS BRUSHING OF TEETH, GOING TO BATHROOM, SHOWERING, CHANGING OF CLOTHES, WASHING CLOTHES, ETC. EACH INTERVIEWED STAFF MEMBER PROVIDED AUDITOR WITH THEIR 1ST RESPONDER CARDS WHEN ASKED. THE 1ST RESPONDER CARDS PROVIDE STAFF WITH THEIR RESPONSIBILITIES WHEN THEY RESPOND TO AN ALLEGATION OF SEXUAL ABUSE. THIS ACTION <u>**EXCEEDS**</u> THIS STANDARD PROVISION.

115.221(b) – N/A – AGENCY DOES NOT HOUSE YOUTHFUL RESIDENTS AT ANY OF THEIR FACILITIES.

115.221(c) – POLICY PREA-005 MANDATES FORENSIC EXAMINATIONS ARE OFFERED AT NO COST FOR VICTIMS OF SEXUAL ABUSE. ALL FORENSIC EXAMINATIONS ARE CONDUCTED AT MEMORIAL HOSPITAL. INTERVIEW WITH SANE NURSE AT MEMORIAL HOSPITAL INDICATES THAT SANE/SAFE NURSES ARE ON STAFF AT ALL TIMES. THEY ARE LOCATED IN-HOUSE AND HAVE THEIR OWN OFFICES AND EXAM ROOMS. STD/HIV/PREGANCY TREATMENT AND EDUCATION ARE PROVIDED. THEY ALSO HAVE AVAILABLE AN IN-HOUSE TESSA ADVOCATE AND LAW ENFORCEMENT ADVOCATE WHO IS ALLOWED TO BE PRESENT DURING FORENSIC EXAMINATION SHOULD THE VICTIM APPROVE.

115.221(d) – FACILITY CONTACTS TESSA RAPE CRISIS CENTER TO MAKE VICTIM ADVOCATE AVAILABLE. INTERVIEW WITH TESSA DIRECTOR INDICATE STAFF ARE AVAILABLE TO PROVIDE ADVOCACY FOR VICTIMS UNDERGOING FORENSIC EXAMINATIONS AT MEMORIAL HOSPITAL. TESSA MOU PROVIDED. TESSA PROVIDES ON-SITE ADVOCACY AND FOLLOWS VICTIM THROUGH NOT ONLY THE INITIAL CRISIS, BUT ALSO THE FORENSIC PROCESS,

PROSECUTORIAL PROCESS AND FOLLOWUP COUNSELING. INTERVIEW WITH PREA COORDINATOR VERIFY TESSA MOU & PROTOCOL. INTERVIEW WITH TESSA DIRECTOR INDICATES TESSA TAKES REPORTS OF SEXUAL ABUSE ALLEGATIONS, PROVIDES ADVOCACY FOR VICTIMS OF SEXUAL ABUSE FROM INCEPTION THROUGHOUT THE INVESTIGATIVE, FORENSIC & COURT PROCESS. THEY ALSO PROVIDE ADVOCACY SUPPORT FOLLOWUP CARE WHEN THE INVESTIGATION AND COURT PROCSS IS COMPLETED. OVER PAST 12 MONTHS, AGENCY INDICATES THERE HAS BEEN NO FORENSIC EXAMINATIONS CONDUCTED.

115.221(e) –INTERVIEW WITH PREA COORDINATOR INDICATE STAFF ADVOCATE IS PROVIDED UPON REQUEST FROM THE VICTIM. THERE ARE CURRENTLY NO AVAILABLE STAFF ADVOCATE.

115.221(f) – STANDARD NOT APPLICABLE TO THIS AGENCY AS THEY ARE RESPONSIBLE FOR ADMINISTRATIVE INVESTIGATIONS ONLY

115.221(g) – STANDARD NOT APPLICABLE TO THIS AGENCY PER DOJ

115.221(h) – STANDARD NOT APPLICABLE TO THIS AGENCY PER DOJ

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY EXCEEDS STANDARD 115.221

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.222(a) – POLICY PREA-007 MANDATES INVESTIGATIONS FOR ALL ADMINISTRATIVE OR CRIMINAL ALLEGATIONS OF SEXUAL ABUSE. 7 ALLEGATIONS OF SEXUAL ABUSE RECEIVED BY FACILITY IN PAST 12 MONTHS, 6 ADMINISTRATIVE AND 1 CRIMINAL INVESTIGATION. INTERVIEW WITH AGENCY HEAD INDICATES COMCOR IS RESPONSIBLE FOR ADMINISTRATIVE INVESTIGATIONS & COLORADO SPRINGS PD IS RESPONSIBLE FOR CRIMINAL INVESTIGATIONS.

115.222(b) – REVIEW OF POLICY PREA-007 & INTERVIEW WITH INVESTIGATIVE STAFF INDICATES COMCOR IS RESPONSIBLE FOR ADMINISTRATIVE INVESTIGATIONS & COLORADO SPRINGS PD IS RESPONSIBLE FOR CRIMINAL INVESTIGATIONS. SEXUAL ABUSE & SEXUAL HARASSMENT ALLEGATIONS REFERRED FOR CRIMINAL INVESTIGATION IS PUBLISHED ON AGENCY WEBSITE IN ANNUAL REPORT WHICH PROVIDES AGGREGATED DATA WITH PERSONAL IDENTIFIERS REDACTED. AUDITOR REVIEWED THE AGENCY WEBSITE AND VERIFIED SEXUAL ABUSE INVESTIGATIONS AND REFERRAL TO APPROPRIATE AGENCY IS PROVIDED.

115.222(c) – POLICY PREA-007 MEETS PREA STANDARDS. RESPONSIBILITY FOR ADMININSTRATIVE & CRIMINAL INVESTIGATIONS ARE OUTLINED IN PREA WEBSITE.

115.222(d) – N/A – STANDARD DOES NOT APPLY TO THIS AGENCY PER DOJ

115.222(e) – N/A – STANDARD DOES NOT APPLY TO THIS AGENCY PER DOJ

AUDITOR HAS DETERMINED THAT AGENCY IS NOT INCOMPLIANCE WITH STANDARD PROVISION 115.222(b)

CORRECTIVE ACTION:
AGENCY TO IMPLEMENT AND PROVIDE VERIFICATION OF THE FOLLOWING CORRECTIVE ACTIONS:

1. **AGENCY TO UPLOAD 2016 ANNUAL REPORT ON AGENCY WEBSITE WHICH PROVIDES AGGREGATED SEXUAL ABUSE & SEXUAL HARASSMENT DATA TO INCLUDE CORRECTIVE ACTIONS OF PREVIOUS YEARS**

2. **PERSONAL IDENTIFIERS REDACTED**

3. **NARRATIVE WHICH INDICATES THE NATURE OF REDACTED MATERIAL**

CORRECTIVE ACTION TO BE COMPLETED NO LATER THAN 10/5/17

CORRECTIVE ACTION COMPLETION 4/23/17:
AGENCY HAS TAKEN THE FOLLOWING CORRECTIVE ACTION MEASURES:

1. AGENCY PROVIDED AUDITOR WITH COPY OF 2016 ANNUAL REPORT WHICH INCLUDES AGGREGATED SEXUAL ABUSE & SEXUAL HARASSMENT DATA FROM 2014 TO 2016
2. REVIEW OF THE 2016 ANNUAL REPORT INDICATES ALL PERSONAL IDENTIFIERS HAVE BEEN REMOVED FROM THE AGGREGATED DATA.
3. 2016 ANNUAL REPORT INCLUDE DISCLAIMER THAT PERSONAL IDENTIFIERS AND SPECIFIC LOCATIONS WHERE INCIDENTS OF SEXUAL ABUSE AND SEXUAL HARASSMENT OCCURRED HAVE BEEN REDACTED FROM THE REPORT AS INCLUSION WOULD PRESENT A CLEAR AND SPECIFIC THREAT TO THE SAFETY AND SECURITY OF THE FACILITY, STAFF AND RESIDENTS.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.222

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.231(a) – POLICY PREA-006 CONTAINS EACH OF THE 10 CRITERIA OULINED IN STANDARD PROVISION 115.231(a). PREA TRAINING IS CONDUCTED AT LEAST ANNUALLY. RANDOM SAMPLE OF 20 STAFF TRAINING RECORDS FOR 2016 VERIFIED COMPREHENSIVE TRAINING RECEIVED THROUGH TRAINING ACKNOWLEDGEMENT FORMS WHICH ARE ALL SIGNED AND INITIALED BY STAFF MEMBER FOR EACH PREA TRAINING CRITERIA. 3 ASSIGNED CONTRACTORS HAVE RECEIVED PREA TRAINING TRAINING CURRICULUM FOR ALL STAFF REVIEWED BY AUDITOR AND IS COMPLIANT WITH PREA STANDARDS AS VERIFIED THROUGH ACKNOWLEDGEMENTS.
115.231(b) – POLICY PREA-006 MANDATES THAT STAFF WILL RECEIVE ADDITIONAL TRAINING IF REASSIGNED FROM FACILITY

THAT HOUSES ONLY MALE CLIENTS TO A FACILITY THAT HOUSES ONLY MALE CLIENTS OR VISA VERSA. REVIEW OF TRAINING CURRICULUM INDICATES STAFF ARE TRAINED TO WORK IN BOTH MALE & FEMALE HOUSING UNITS. SHOULD A STAFF MEMBER BE REASSIGNED TO WORK IN A FACILITY WHICH IS OF A GENDER FROM THE ORIGINAL FACILITY HE/SHE CAME FROM, THAT STAFF MEMBER WILL RECEIVE ADDITIONAL TRAINING. DIVERSION FACILITY HOUSES BOTH MALE AND FEMALE STAFF.

115.231(c) – POLICY PREA-006 MANDATES STAFF RECEIVE ANNUAL PREA TRAINING & REFRESHER TRAINING DURING MONTHLY STAFF MEETINGS. AGENCY REPORTS 100% OF STAFF EMPLOYED BY FACILITY HAVE RECEIVED PREA TRAINING. INTERVIEW WITH STAFF VERIFIES ALL ARE WELL VERSED IN THE CRITERIA OUTLINED IN THEIR PREA TRAINING. AGENCY IDENTIFIED 25 STAFF EMPLOYED BY FACILITY WHO MAY HAVE CONTACT WITH INMATES. 100% WERE TRAINED OR RETRAINED IN PREA REQUIREMENTS. REFRESHER TRAINING IS PROVIDED ANNUALLY THROUGH MONTHLY STAFF MEETINGS.

115.231(d) – AGENCY MANDATES TRAINING ACKNOWLEDGEMENT VIA PREA ACKNOWLEDGEMENT TRAINING FORMS WHICH MUST BE SIGNED BY THE TRAINING STAFF & EMPLOYEE. EMPLOYEE MUST INITIAL EACH TRAINING CRITERIA AS EACH CHAPTER IS COMPLETED TO ACKNOWLEDGE UNDERSTANDING OF THE TRAINING AREA. REVIEW OF 20 TRAINING RECORD ACKNOWLEDGEMENTS VERIFY THIS PRACTICE IS INSTITUTIONALIZED.

RECOMMENDATION: Place copy of VOIANCE contact information in the Tech Office and train staff of it's location and use.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.231

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.232(a) – AGENCY EMPLOYS 1 VOLUNTEER & 4 CONTRACTORS. ALL HAVE RECEIVED PREA TRAINING AS VERIFIED THROUGH THEIR TRAINING RECORDS. INTERVIEW WITH VOLUNTEER INDICATES HE RECEIVED PREA TRAINING AS VERIFIED BY TRAINING ACKNOWLEDGEMENT. CONTRACTOR INDICATES SHE RECEIVED REFRESHER TRAINING AND ADDITIONAL TRAINING AS SHE IS A MEDICAL PRACTITIONER PER PREA-006.

115.232(b) – POLICY PREA-006 MANDATES LEVEL & TYPE OF TRAINING PROVIDED VOLUNTEERS & CONTRACTORS SHALL BE BASEDON THE SERVICES THEY PROVIDE & LEVEL OF CONTACT THEY HAVE WITH RESIDENTS. INTERVIEW WITH BOTH VOLUNTEER AND RANDOM CONTRACTOR SELECTION VERIFIED AGENCY MEETS THIS STANDARD. TRAINING CURRICULUM REVIEWED BY AUDITOR & MEETS PREA STANDARD 115.222(b).

115.232(c) – AGENCY MANDATES DOCUMENTATION VIA VOLUNTEER/CONTRACTOR PREA TRAINING ACKNOWLEDGEMENT FORM WHERE TRAINEE MUST SIGN & DATE ACKNOWLEDGEMENT OF TRAINING RECEIVED. FORM IS ALSO SIGNED AND DATED BY TRAINER. DOCUMENTS OF ACKNOWLEDGEMENT OBTAINED AND REVIEWED BY AUDITOR.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.232

Standard 115.233 Resident education

█ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.233(a) – INTERVIEW WITH RANDOM SAMPLE OF 20 RESIDENTS & INFORMAL INTERVIEW OF RESIDENTS INDICATE THEY RECEIVE PREA QUESTIONS VIA INTAKE STAFF & MANDATED TO WATCH PREA VIDEO UPON INTAKE & PROVIDED PREA BROCHURE. INTERVIEW WITH INTAKE STAFF VERIFIES RESIDENTS ARE TRAINED & KNOWLEDGEABLE IN PREA & CLIENT EDUCATION. AUDITOR VIEWED PREA POSTERS & BROCHURES IN BOTH ENGLISH & SPANISH. 20 INTAKE SCREENING RECORDS WERE REVIEWED IN CATS DATA SYSTEM WHICH VERIFIED INTAKE RESIDENT PREA EDUCATION TRAINING CONDUCTED WITH ALL RESIDENTS REVIEWED. AGENCY INDICATES THAT OVER THE PAST 12 MONTHS, 426 RESIDENTS WERE ADMITTED TO FACILITY AND 100% WERE PROVIDED PREA EDUCATION AT INTAKE.

115.233(b) – POLICY PREA-001 INCLUDES NARRATIVE CONSISTENT WITH STANDARD MANDATES. INTERVIEW WITH INTAKE STAFF INDICATES ALL RESIDENTS TRANSFERRED BETWEEN FACILITIES ARE PROVIDED WITH REFRESHER INFORMATION AND EDUCATION REGARDING PREA. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE ONE RESIDENT WAS TRANSFERRED BETWEEN RESIDENTIAL THIS RESIDENT INDICATES HE WAS PROVIDED REFRESHER TRAINING UPON INTAKE AT THE NEW FACILITY TO INCLUDE WATCHING THE PREA VIDEO PRIOR TO HOUSING. AUDITOR VERIFIED RESIDENT'S STATEMENT AND STAFF'S DEMONSTRATION OF POLICY DURING REVIEW OF HIS SCREENING RECORDS.

115.233(c) – RESIDENT EDUCATION MATIERIALS REVIEWED BY AUDITOR. ZERO TOLERANCE & PREA NOTICES AVAILABLE IN BOTH ENGLISH & SPANISH LOCATED IN COMMON AREAS ACCESSIBLE TO RESIDENTS. PREA BROCHURES HANDED TO EACH RESIDENT AT INTAKE WRITTEN IN BOTH ENGLISH & SPANISH. MOU WITH VOIANCE LANGUAGE INTERPRETERS TO PROVIDE COMMUNICATION SERVICES TO DISABLED OR LIMITED ENGLISH PROVICIENT RESIDENTS. POLICY PREA-001 MEETS PREA STANDARDS TO PROVIDE LANGUAGE SERVICES & VARIOUS EDUCATIONAL FORMATS TO DISABLED RESIDENTS & RESIDENTS WITH LIMITED READING SKILLS. INTERVIEW WITH 2 DISABLED RESIDENTS INDICATE STAFF PROVIDE PREA EDUCATION IS VARIOUS METHODS TO ENSURE RESIDENTS ARE INFORMED OF REPORTING METHODS, THEIR RIGHTS & ZERO-TOLERANCE POLICY.

115.233(d) – POLICY PREA-001 PAGE #3 MANDATES THAT WITHIN 7 DAYS OF ADMISSION THE CLIENT WILL REVIEW THE CLIENT EDUCATION VIDEO. THE CLIENT AND A STAFF MEMBER WILL SIGN THE CLIENT EDUCATION ACKNOWLEDGEMENT FORM, WHICH WILL BE FILED IN THE CLIENT'S PERMANENT FILE UNDER "RULES". THE DATE WILL BE ENTERED INTO CATS! ON THE CLIENT PROGRAM SCREEN, COMPLIANT WITH STANDARD 115.233(d). DOCUMENTATION OF RESIDENT EDUCATION PROCESS REVIEWED & CATS ENTRIES REVIEWED BY AUDITOR DURING ON-SITE AUDIT OBSERVATION.

115.233(e) – AUDITOR VIEWED PREA RESIDENT HANDBOOKS POSTERS & BROCHURES IN BOTH ENGLISH & SPANISH. INTERVIEW WITH RESIDENTS VERIFY POSTERS THROUGHOUT THE FACILITY IN EVERY HOUSING UNIT, COMMON AREAS FREQUENTED BY RESIDENTS TO INCLUDE DINING AREA, EDUCATION & COUNSELING AREAS TO INCLUDE NEXT TO EACH FACILITY TELEPHONE. PREA POSTERS ARE LOCATED BEHIND THE DOOR IN EACH HOUSING UNIT. POSTERS AND PREA BROCHURES DO NOT PROVIDE LIMITS OF CONFIDENTIALITY & MONITORING INFORMATION. AUDITOR VISITED THESE AREAS TO VERIFY PLACEMENT AND AVAILABILITY OF THE INFORMATION TO RESIDENTS. AUDITOR DETERMINES AGENCY **EXCEEDS** THIS STANDARD IN PROVIDING CONTINUOUS AND READILY AVAILABLE WRITTEN PREA COMMUNICATION.

RECOMMENDATION: Inform residents of who the PREA investigators are, in writing.

AUDITOR HAS DETERMINED THAT AGENCY IS NOT INCOMPLIANCE WITH STANDARD PROVISION 115.233(e)

CORRECTIVE ACTION:
AGENCY TO IMPLEMENT AND PROVIDE VERIFICATION OF THE FOLLOWING CORRECTIVE ACTIONS:

1. **AGENCY TO INCLUDE LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING ABILITY FOR CONTACT BETWEEN RESIDENTS AND OUTSIDE ADVOCACY OR REPORTING AGENCIES.**

2. **AGENCY TO PROVIDE VERIFICATION THAT LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING CAPABILITY IS PROVIDED IN THE PREA POSTERS.**

CORRECTIVE ACTION TO BE COMPLETED NO LATER THAN 10/5/17

CORRECTIVE ACTION COMPLETION 5/10/17:
AGENCY HAS TAKEN THE FOLLOWING CORRECTIVE ACTION MEASURES:

1. AGENCY PROVIDED AUDITOR WITH AMENDED PREA BROCHURES IN BOTH ENGLISH & SPANISH WHICH PROVIDES FOR LIMITS OF CONFIDENTIALITY, MONITORING OF CALLS TO OUTSIDE AGENCIES FOR ADVOCACY & REPORTING. BROCHURES INCLUDE GRIEVANCE SUBMISSION PROCEDURES WHICH INDICATES THERE IS NO TIME LIMIT AND INCLUDES INFORMATION ON OBTAINING & SUBMITTING GRIEVANCES THROUGH THE LOCKED BOXES PROVIDED IN EACH FACILITY WHERE ONLY THE CORRECTIONAL SUPERVISORS HAVE ACCESS.
2. AGENCY PROVIDED AUDITOR WITH PHOTOS OF PREA POSTERS IN VARIOUS LOCATIONS THROUGHOUT THE FACILITY WHICH PROVIDE CONTACT INFORMATION FOR AGENCIES LOCATED OUTSIDE OF COMCOR INC., WHICH PROVIDE EMOTIONAL SUPPORT AND CAN BE USED FOR REPORTING ALLEGATIONS OF SEXUAL ABUSE. POSTERS ALSO INCLUDE NARRATIVE WHICH PROVIDES FOR LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING INFORMATION.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.233

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.234(a) – POLICY PREA-006 MANDATES DESIGNATED INTERNAL PREA INVESTIGATORS TO BE TRAINED IN CONDUCTING

SEXUAL ABUSE INVESTIGATIONS IN A CONFINEMENT SETTING. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES STAFF RECEIVED SPECIAL INVESTIGATOR TRAINING TO CONDUCT SEX ABUSE INVESTIGATION IN A CONFINEMENT SETTING PER POLICY PREA-006 AND PREA STANDARD 115.234. NIC CURRICULUM AND INVESTIGATOR TRAINING RECORDS REVIEWED TO VERIFY COMPLIANCE. COMCOR INC EMPLOYS 4 SPECIAL INVESTIGATORS TO INVESTIGATE ADMINISTRATIVE INVESTIGATIONS ONLY.

115.234(b) – AGENCY DOES NOT COLLECT EVIDENCE OR ISSUE MIRANDA/GARRITY RIGHTS TO CLIENTS. CSPD IS RESPONSIBLE FOR BOTH TASKS. AGENCY STAFF PRESERVES SCENE FOR EVIDENCE COLLECTION BY CSPD. INVESTIGATORS ARE TRAINED IN MIRANDA/GARRITY RIGHTS TO CLIENTS VIA SPECIAL INVESTIGATOR TRAINING. NIC CURRICULUM AND INVESTIGATOR TRAINING RECORDS REVIEWED TO VERIFY COMPLIANCE. INTERVIEW WITH SPECIAL INVESTIGATOR ALSO VERIFIED COMPLIANCE.

115.234(c) – AGENCY CURRENTLY EMPLOYS 4 SEXUAL ABUSE INVESTIGATORS WHO HAVE COMPLETED THE REQUIRED TRAINING. REVIEW OF SPECIAL INVESTIGATOR TRAINING RECORDS VERIFY POSSESSION OF NIC SPECIAL INVESTIGATOR TRAINING FOR SEX ABUSE INVESTIGATION IN A CORRECTIONAL SETTING FOR ALL 4 IDENTIFIED SPECIAL INVESTIGATORS.

115.234(d) – N/A – STANDARD PROVISION DOES NOT APPLY TO AGENCY PER DOJ.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.234

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.235(a) – DIVERSION FACILITY HAS ONE VOLUNTEER, ONE MEDICAL AND ONE MENTAL HEALTH CONTRACTOR EMPLOYED BY AGENCY PART TIME AND ASSIGNED TO THE DIVERSION FACILITY. ALL 3 HAVE COMPLETED THE REQUIRED PREA TRAINING. POLICY PREA-006 MANDATES MENTAL HEALTH PROFESSIONALS THAT WORK REGULARLY AT COMCOR INCLUDING FULL OR PART TIME EMPLOYEES, VOLUNTEERS OR CONTRACTORS, 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; TO AND
4. HOW AND TO WHOM TO REPORT ALLEGATIONS OR SUSPICIONS OF SEXUAL ABUSE AND SEXUAL HARASSMENT.
5. COMCOR STAFF DOES NOT CONDUCT FORENSIC EXAMINATIONS.
6. COMCOR SHALL MAINTAIN DOCUMENTATION THAT MENTAL HEALTH PROFESSIONALS HAVE RECEIVED THE TRAINING REFERENCED IN THIS STANDARD EITHER FROM COMCOR OR ELSEWHERE.
7. MENTAL HEALTH PROFESSIONALS ALSO RECEIVE ALL OTHER MANDATED TRAINING.

115.235(b) – N/A – NO FORENSIC MEDICAL EXAMS CONDUCTED BY STAFF AT THIS FACILITY. ALL FORENSIC MEDICAL EXAMINATIONS ARE CONDUCTED AT MEMORIAL HOSPITAL.

115.235(c) – SIGNED PREA CONTRACTOR/VOLUNTEER ACKNOWLEDGEMENT FORM & SIGNED PREA ACKNOWLEDGEMENT

FORM FOR POLICIES & PROCEDURES FOR REPORTING OF A PREA INCIDENT HAS BEEN PROVIDED TO AUDITOR. BOTH MENTAL HEALTH CONTRACTORS ARE IN COMPLIANCE WITH STANDARD 115.235(c).

115.235(d) – ALL CONTRACTORS HAVE RECEIVED ADDITIONAL TRAINING IN ADDITION TO PREA TRAINING DUE TO THEIR CONTACT WITH RESIDENTS. AGENCY IS IN COMPLIANCE WITH STANDARD 115.235(d).

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.235

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.241(a) – POLICY PREA-002 MANDATES THAT WITHIN 72 HOURS OF ADMISSION AND UPON TRANSFER TO ANOTHER COMCOR RESIDENTIAL FACILITY, STAFF CONDUCTS A RISK ASSESSMENT ON ALL RESIDENTIAL CLIENTS USING THE APPROPRIATE INSTRUMENT LOCATED IN THE CLIENT'S CATS RECORD. CATS ELECTRONIC RECORD WAS REVIEWED ON SAMPLE OF RESIDENT FILES & FOUND THE RISK ASSESSMENT WAS CONDUCTED APPROPRIATELY WITHIN TIMEFRAMES. INTERVIEW WITH SCREENING STAFF INDICATE THEY FOLLOW POLICY & CATS SYSTEM PROVIDES FOR ERROR NOTIFICATION TO MANAGEMENT IF THE 72 HOUR DEADLINE HAS PASSED. REVIEW OF 20 RANDOM SAMPLE OF RESIDENT SCREENING FILES INDICATE THAT ONLY ONE RECORD WAS FOUND TO BE ONE DAY LATE OF THE 72 HOUR DEADLINE

115.241(b) – POLICY PREA-002 MANDATES THAT WITHIN 72 HOURS OF ADMISSION AND UPON TRANSFER TO ANOTHER COMCOR RESIDENTIAL FACILITY, STAFF CONDUCTS A RISK ASSESSMENT ON ALL RESIDENTIAL CLIENTS USING THE APPROPRIATE INSTRUMENT LOCATED IN THE CLIENT'S CATS! RECORD. INTERVIEW WITH BOTH RANDOM RESIDENTS AND SCREENING STAFF INDICATE THEY FOLLOW POLICY & CATS SYSTEM PROVIDES FOR ERROR NOTIFICATION TO MANAGEMENT IF THE 72 HOUR DEADLINE HAS PASSED. REVIEW OF 20 RANDOM SAMPLE OF RESIDENT SCREENING FILES INDICATE THAT ONLY ONE RECORD WAS FOUND TO BE ONE DAY LATE OF THE 72 HOUR DEADLINE. AGENCY CLAIMS 393 RESIDENTS ENTERED THE FACILITY WHOSE LENGTH OF STAY IN THE FACILITY WAS FOR 72 HOURS OR MORE. AGENCY INDICATES 100% OF THOSE RESIDENTS WERE SCREENED FOR RISK OF SEXUAL VICTIMIZATION OR RISK OF SEXUALLY ABUSING OTHER RESIDENTS WITHIN 72 HOURS OF THEIR ENTRY INTO THE FACILITY. RANDOM SAMPLE OF 20 RESIDENT SCREENING RECORDS VERIFIES RESIDENTS RECEIVE INTAKE SCREENING EITHER THE SAME DAY OF INTAKE OR THE DAY AFTER INTAKE.

115.241(c) – THE CATS SYSTEM (COMCOR AUTOMATED TRACKING SYSTEM) IS AN AWARD-WINNING ELECTRONIC OBJECTIVE SCREENING TOOL UTILIZED FOR BOTH DOC AND BOP RESIDENTS. IT IS USED IN CONJUNCTION WITH THE COLORADO DIVISION OF CRIMINAL JUSTICE VICTIM/PREDATOR SCREENING INSTRUMENT AND THE COLORADO DEPT. OF CORRECTIONS PREA RISK ASSESSMENT INSTRUMENT.

115.241(d) – INTAKE SCREENING INSTRUMENT PROVIDED & OBSERVED DURING ON-SITE TOUR. ALL 9 PREA CRITERIA IDENTIFIED IN STANDARD 115.241(d) IS UTILIZED WITHIN THE SCREENING TOOL TO ASSESS RESIDENTS FOR RISK OF SEXUAL VICTIMIZATION.

115.241(e) – REVIEW OF SCREENING INSTRUMENT & INTERVIEW WITH STAFF RESPONSIBLE FOR RISK SCREENING VERIFIES THE SCREENING INSTRUMENT ASKS FOR RESPONSE TO THIS CRITERIA, BUT THE SCREENER ALSO CONSIDERS THE RESPONSES & PLACES IN CATS, UTILIZING THE CHECKLIST COMMENTS SECTION IN PAPER FORM TO KEEP IN

FILE

115.241(f) – POLICY PREA-002 STATES THAT WITHIN 30 DAYS OF THE CLIENT ARRIVAL AT THE FACILITY, THE CASE MANAGER WILL REASSESS THE CLIENTS RISK OF VICTIMIZATION OR ABUSIVENESS. AGENCY REPORTS 47 RESIDENTS ENTERED THE FACILIT WITHIN THE PAST 2 MONTHS WHOSE LENGTH OF STAY IN THE FACILITY WAS FOR 30 DAYS OR MORE WHO WERE REASSESSED FOR THEIR RISK OF SEXUAL VICTIMIZATION OR OF BEING SEXUALLY ABUSIVE WITHIN 30 DAYS AFTER THEIR ARRIVAL AT THE FACILITY BASED UPON ANY ADDITIONAL, RELEVANT, INFORMATION RECEIVED AT INTAKE. INTERVIEW WITH RANDOM SAMPLE OF 12 RESIDENTS INDICATED THE MAJORITY REMEMBER A REASSESSMENT. RISK SCREENING STAFF INDICATE WITHIN 30 DAYS ALL RESIDENTS ARE REASSESSED. CATS AUTOMATED DATA SYSTEM ALERTS BOTH CASE MANAGERS AND UPPER MANAGEMENT WHEN THE 20 DAY MARK IS REACHED TO ENSURE REASSESSMENT DEADLINE IS NOT BREACHED. REVIEW OF 20 SAMPLE RESIDENT SCREENING RECORDS INDICATE 19 RESIDENTS WHO ARRIVED IN LAST 12 MONTHS WERE REASSESSED BY CASE MANAGER WITHIN 30 DAYS AFTER THEIR ARRIVAL AT THE FACILITY. ONE CASE WAS CAPTURED WHERE THE RESIDENT WAS SCREENED IN 2014 AND DID NOT RECEIVE A 30 DAY REASSESSMENT.

115.241(g) – POLICY PREA-002 MANDATES 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. CLIENTS' MAY NOT BE DISCIPLINED FOR REFUSING TO ANSWER, OR FOR NOT DISCLOSING COMPLETE INFORMATION IN RESPONSE TO QUESTIONS IN THIS SECTION. WITHIN 30 DAYS OF THE CLIENT ARRIVAL AT THE FACILITY, THE CASE MANAGER WILL REASSESS THE CLIENT'S RISK OF VICTIMIZATION OR ABUSIVENESS BASED UPON ANY ADDITIONAL AND RELEVANT INFORMATION RECEIVED BY THE FACILITY SINCE THE INTAKE PREA SCREEN/ASSESSMENT. REVIEW OF 20 SAMPLE RESIDENT SCREENING RECORDS INDICATE ALL RESIDENTS WHO ARRIVED AFTER MARCH 2015 WERE REASSESSED BY CASE MANAGER WITHIN 30 DAYS AFTER THEIR ARRIVAL AT THE FACILITY. AGENCY ADOPTED A PROCEDURE TO IMPLEMENT REASSESSMENT OF ALL RESIDENTS WITHIN 21 TO 30 DAYS OF ENTERING THE FACILITY. AUDITOR HAS DETERMINED AGENCY EXCEEDS STANDARD PROVISION 115.241(g) REQUIREMENT.

115.241(h) –POLICY PREA-002 MANDATES RESIDENTS MAY NOT BE DISCIPLINED FOR REFUSING TO ANSWER FOR NOT RESPONDING TO QUESTIONS DURING SCREENING.
INTERVIEW WITH SCREENING STAFF INDICATE COMCOR INC STAFF FOLLOW PROCEDURES OUTLINED IN POLICY & IT IS IDENTIFIED IN RESIDENT HANDBOOK.

115.241(I) – POLICY PREA-002 MANDATES IMPLEMENTATION OF APPROPRIATE CONTROLS ON THE DISSEMINATION OF RESPONSES TO QUESTIONS ASKED PURSUANT TO SCREENING INFORMATION TO ENSURE SENSITIVE INFORMATION IS NOT EXPLOITED TO THE RESIDENT'S DETRIMENT BY STAFF OR OTHER RESIDENTS. INTERVIEWS WITH PREA COORDINATOR AND RISK SCREENING STAFF INDICATE RISK SCREENING FILES ARE MAINTAINED IN A SECURE LOCATION IN THE TECHNICIANS OFFICE. ONLY CASE MANAGEMENT STAFF, FACILITY MANAGERS AND AUTHORIZED USERS OF SENSITIVE ELECTRONIC FILES ARE ALLOWED ACCESS TO THIS INFORMATION.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.241

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.242(a) – BED ASSIGNMENT PREA SNAPSHOT PROVIDED. SEXUAL ORIENTATION QUESTIONAIRE, RISK SCREENING INSTRUMENTS DOC PREA RISK ASSESSMENT & PREA RISK ASSESSMENT FOR BOP RESIDENTS ARE UTILIZED TO PROVIDE HOUSING, PROGRAM ASSIGNMENTS, WORK, EDUCATION ETC. INTERVIEW WITH PREA COORDINATOR & RISK SCREENING STAFF INDICATE COMPATIBILITY DETERMINATION IS BASED ON INITIAL ASSESSMENT, SCREENING & REASSESSMENT.

115.242(b) – PER POLICY PREA-002, COMCOR CORRECTIONAL SUPERVISORS WILL REVIEW ALL ROOM ASSIGNMENTS IN ORDER TO MAKE AND DOCUMENT INDIVIDUALIZED DETERMINATION ABOUT HOW TO ENSURE THE SAFETY OF EACH RESIDENTIAL CLIENT ON A CASE BY CASE BASIS. DOCUMENTATION OF THESE REVIEWS IS RECORDED IN CATS ELECTRONIC DATABASE PER INTERVIEW WITH SCREENING STAFF.

115.242(c) – PER POLICY PREA-002, COMCOR CORRECTIONAL SUPERVISORS WILL REVIEW ALL ROOM ASSIGNMENTS IN ORDER TO MAKE AND DOCUMENT INDIVIDUALIZED DETERMINATION ABOUT HOUSING AND PROGRAM ASSIGNMENTS FOR TRANSGENDER OR INTERSEX CLIENTS IN A FACILITY ON A CASE BY CASE BASIS TO ENSURE THEIR SAFETY.
DOCUMENTATION OF THESE REVIEWS WILL BE RECORDED IN CATS! PER INTERVIEW WITH PREA COORDINATOR. NO TRANSGENDER/INTERSEX RESIDENTS HOUSED IN THE FACILITY DURING THE ON-SITE AUDIT.

115.242(d) – POLICY PREA-002 MANDATES TRANSGENDER OR INTERSEX RESIDENTS OWN VIEWS WITH RESPECT TO HIS OR HER OWN SAFETY SHALL BE GIVEN SERIOUS CONSIDERATION. INTERVIEW WITH BOTH PREA COORDINATOR & SCREENING STAFF VERIFY USE OF POLICY TO INCLUDE SECURITY OF THE FACILITY IS ALSO CONSIDERED.

115.242(e) – POLICY PREA-018 PROVIDES FOR TRANSGENDER & INTERSEX RESIDENTS BE ALLOWED TO SHOWER SEPARATELY FROM OTHER RESIDENTS. DURING FACILITY TOUR, AUDITOR OBSERVED SEPARATE SHOWER AND BATHROOMS WITH DOORS ON EACH WHICH IS PROVIDED INSIDE EACH RESIDENT ROOM. THE SHOWER ALSO HAS A SCREEN, SO IF THE DOOR IS OPEN, RESIDENT IS STILL PROVIDED PRIVACY. INTERVIEW WITH PREA COORDINATOR & RISK SCREENING STAFF VERIFY COMPLIANCE WITH STANDARD.

115.242(f) – POLICY PREA-018 PROHIBITS PLACEMENT OF LGBTI RESIDENTS IN DEDICATED FACILITYIES SOLELY ON THE BASIS OF SUCH IDENTIFICATION OR STATUS. THERE IS NO LAWFUL CONSENT DECREE OR LEGAL JUDGEMENT MANDATING SUCH ACTIONS, OR ESTABLISHED UNIT IN COMCOR INC FOR THAT PURPOSE. INTERVIEW WITH PREA COORDINATOR VERIFIES POLICY IN ACTION. ALL INDICATE RESIDENTS ARE TREATED WITH DIGNITY & RESPECT BY COMCOR STAFF & MANAGEMENT.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.242

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.251(a) – POLICY PREA-003 MANDATES AGENCY TO PROVIDE MULTIPLE INTERNAL WAYS FOR RESIDENTS TO PRIVATELY REPORT SEXUAL ABUSE /HARASSMTNE. INFORMATION FOR RESIDENTS IS PROVIDED IN RESIDENT BROCHURES & NOTIFICATION LITERATURE IN ENGLISH & SPANISH. LIMITS OF CONFIDENTIALITY, AGENCY MONITORING POLICY AND MANDATORY REPORTING INFORMATION IS NOT PROVIDED IN THE BROCHURES. ALLEGATION OF

SEXUAL ABUSE REPORTING PROCEDURES AND CONTACT INFORMATION TO OUTSIDE ADVOCATE AGENCIES IS PROVIDED TO RESIDENTS ON THE BROCHURES. PROOF OF RECIEPT OF PREA REPORTING EDUCATION MUST BE SIGNED BY RESIDENT AND INTAKE STAFF FOR VERIFICATION AT INTAKE. PREA POSTERS IN BOTH ENGLISH & SPANISH TO PROVIDE EFFECTIVE COMMUNICATION FOR REPORTING BUT FAILS TO PROVIDE LIMITS OF CONFIDENTIALITY, AGENCY MONITORING. TESSA RAPE CRISIS HOTLINE, ACTIVATION VERIFIED BY AUDITOR, PROVIDES FOR TOLL FREE COMMUNICATION TO OUTSIDE AGENCIES. INTERVIEW WITH RANDOM SAMPLING OF 15 STAFF VERIFIES RESIDENTS ACCESS TO TOLL FREE COMMUNICATION TO OUTSIDE AGENCIES. RANDOM SAMPLING OF 20 RESIDENTS INDICATED TOLL FREE PHONE NUMBERS ARE PROVIDED IN PREA POSTERS WITHIN THE FACILTIY. RESIDENTS CAN ALSO PRIVATELY REPORT TO DOC & COMCOR INC. MANAGEMENT STAFF.

115.251(b) – INTERVIEW WITH PREA COORDINATOR & RANDOM SAMPLE OF RESIDENTS INDICATE ACCESS TO TESSA RAPE CRISIS CENTER FOR PRIVATE REPORTING & DOC HOTLINE BOTH OF WHICH PROVIDE ACCESS NUMBERS ON PREA POSTERS ACCESSIBLE TO RESIDENTS IN ALL COMMON AREAS. TESSA MOU PROVIDED.

115.251(c) – POLICY PREA-003 COMPLIANT WITH THIS STANDARD. INTERVIEW WITH RANDOM SAMPLE OF 15 STAFF & RESIDENTS INDICATE STAFF IS TRAINED TO ACCEPT REPORTS IN THE VARIOUS CRITERIA MENTIONED IN THIS STANDARD & REPORT ANY ALLEGATIONS OF SEX ABUSE/HARASSMENT IMMEDIATELY. RESIDENTS INDICATE BEING COMFORTABLE WITH REPORTING TO STAFF VERBALLY, IN WRITING, ANNONYMOUSLY AND FROM 3RD PARTIES & CONFIDENT STAFF WILL FOLLOW UP IMMEDIATELY WITH WRITTEN REPORT & INVESTIGATION.

115.251(d) – STAFF ARE PROVIDED METHODS OF PRIVATE REPORTING THROUGH SENIOR COMCOR MANAGERS, COLORADO SPRINGS PD, DOC TIP LINE AND TESSA. THIS INFORMATION IS PROVIDED IN THE INITIAL PREA STAFF TRAINING AND THE ANNUAL REFRESHER TRAINING SESSIONS. REVIEW OF TRAINING CURRICULUM VERIFY TRAINING WITH REGARDS TO STAFF PRIVATELY REPORTING IS DISCUSSED.

AUDITOR HAS DETERMINED THAT AGENCY IS NOT INCOMPLIANCE WITH STANDARD PROVISION 115.251(a)

CORRECTIVE ACTION:

AGENCY TO IMPLEMENT AND PROVIDE VERIFICATION OF THE FOLLOWING CORRECTIVE ACTIONS:

1. **AGENCY TO INCLUDE LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING ABILITY FOR CONTACT BETWEEN RESIDENTS AND OUTSIDE ADVOCACY OR REPORTING AGENCIES.**

CORRECTIVE ACTION TO BE COMPLETED NO LATER THAN 10/5/17

CORRECTIVE ACTION COMPLETION 5/10/17:

AGENCY HAS TAKEN THE FOLLOWING CORRECTIVE ACTION MEASURES:

1. AGENCY PROVIDED AUDITOR WITH PHOTOS OF PREA POSTERS IN VARIOUS LOCATIONS THROUGHOUT THE FACILITY WHICH PROVIDE CONTACT INFORMATION FOR AGENCIES LOCATED OUTSIDE OF COMCOR INC., WHICH PROVIDE EMOTIONAL SUPPORT AND CAN BE USED FOR REPORTING ALLEGATIONS OF SEXUAL ABUSE. POSTERS ALSO INCLUDE NARRATIVE WHICH PROVIDES FOR LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING INFORMATION.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.251

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.252(a) – PREA MANDATES OUTLINED IN POLICY & IS COMPLIANT WITH STANDARD 115.252(a) REGARDING GRIEVANCE POLICY.

115.252(b) – PREA POLICY IDS-006 MANDATES NO TIME LIMIT ON PREA ALLEGATION GRIEVANCES. POLICY GOES ON TO MEET ALL 4 CRITERIA IN IT'S NARRATIVE. RESIDENT BROCHURE GRIEVANCE NARRATIVE PROVIDES INSTRUCTIONS FOR RESIDENT TO SUBMIT SEXUAL ABUSE GRIEVANCE IN LOCKED BOXES PROVIDED IN EACH HOUSING UNIT AND THE PROCEDURE FOR AGENCY TO OBTAIN AND PROCESS EACH GRIEVANCE. DURING ON-SITE AUDIT RESIDENT INTERVIEWS, RESIDENT INFORMED AUDITOR THEY HAD TO OBTAIN GRIEVANCE FORMS FROM STAFF IN TECH OFFICE BEFORE THEY CAN SUBMIT IN LOCKED BOX FOR ACTION. THIS WAS VERIFIED THROUGH INTERVIEW WITH PREA COORDINATOR AND OTHER STAFF MEMBERS.

115.252(c) – POLICY IDS-006 MANDATES AGENCY DOES NOT REQUIRE A CLIENT TO USE ANY GRIEVANCE PROCESS OR ATTEMPT TO RESOLVE WITH STAFF AN ALLEGED INCIDENT OF SEXUAL ABUSE, NOR DOES IT REQUIRE A GRIEVANCE REFERRAL TO A STAFF MEMBER WHO IS THE SUBJECT OF THE COMPLAINT. RELEVANT INFORMATION IS PROVIDED IN RESIDENT HANDBOOK/BROCHURE. POLICY PROVIDES METHOD AND PROCEDURE FOR RESIDENTS TO SUBMIT SEXUAL ABUSE/HARASSMENT ANONYMOUSLY. POLICY INCLUDES NARRATIVE OUTLINING THE PROCESSING OF SAID GRIEVANCES. POLICY GRIEVANCE NARRATIVE IS INCLUDED IN THE INMATE BROCHURE WHICH IS PROVIDED TO RESIDENTS IN BOTH ENGLISH & SPANISH.

115.252(d) – POLICY IDS-006 PROVIDES TIMEFRAMES AGENCY ISSSUES A FINAL DECISION ON THE MERITS OF ANY PORTION OF A GRIEVANCE ALLEGING SEXUAL ABUSE AND EXTENSION TIMEFRAMES IN ACCORDANCE WITH STANDARD PROVISION 115.252(d). AGENCY REPORTS NO GRIEVANCES ALLEGING SEXUAL ABUSE WAS FILED BY A RESIDENTS IN THE PAST 12 MONTHS.

115.252(e) – POLICY IDS-006 ALLOWS FOR 3RD PARTIES ASSISTING RESIDENTS IN FILING REQUESTS FOR ADMININSTRATIVE REMEDIES. COMCOR MAY REQUIRE THE ALLEGED VICTIM TO PERSONALLY PURSUE ANY SUBSEQUENT STEPS IN THE ADMNISTRATIVE REMEDY PROCESS. POLICY ALSO MANDATES IF CLIENT DECLINES TO HAVE THE GRIEVANCE REQUEST PROCESSED ON HIS OR HER BEHALF, COMCOR SHALL DOCUMENT THE CLIENTS DECISION. NO GRIEVANCES REQUIRING OR IDENTIFING A DECLINED OFFER OF 3RD PARTY ASSISTANCE FILED BY RESIDENTS OVER THE PAST 12 MONTHS.

115.252(f) – EMERGENCY GRIEVANCE PROCEDURES OUTLINED IN POLICY IDS-006 ESTABLISHES PROCEDURES FOR FILING AN EMERGENCY GREIVANCE ALLEGING RESIDENT IS SUBJECT TO A SUBSTANTIAL RISK OF IMMINENT SEXUAL ABUSE, REQUIRING AN INITIAL RESPONSE WITHIN 48 HOURS. NO GRIEVANCES ALLEGING IMMINENT SEXUAL ABUSE SUBMITTED BY RESIDENT OVER PAST 12 MONTHS.

115.252(g) – POLICY IDS-006 MANDATES THE AGENCY MAY DISCIPLINE A RESIDENT FOR FILING A GREIVANCE RELATED TO ALLEGED SEXUAL ABUSE ONLY WHERE THE AGENCY DEMONSTRATES RESIDENT FILED THE GREIVANCE IN BAD FAITH. NO BAD FAITH GRIEVANCES ALLEGING SEXUAL ABUSE FILED OVER PAST 12 MONTHS.

AUDITOR HAS DETERMINED THAT AGENCY IS NOT INCOMPLIANCE WITH STANDARD PROVISIONS 115.252(b) & 115.252(e)

CORRECTIVE ACTION:
AGENCY TO IMPLEMENT AND PROVIDE VERIFICATION OF THE FOLLOWING CORRECTIVE ACTIONS:

1. **AGENCY TO EMPLOY METHOD IN WHICH RESIDENTS CAN OBTAIN AND SUBMIT GRIEVANCE FORMS WITHOUT OBTAINING OR SUBMITTING TO A STAFF MEMBER DIRECTLY.**
2. **AGENCY TO PROVIDE EFFECTIVE COMMUNICATION TO INMATES TO INFORM THEM OF THIS GRIEVANCE PROCEDURE**

CORRECTIVE ACTION TO BE COMPLETED NO LATER THAN 10/5/17

CORRECTIVE ACTION COMPLETION 4/21/17
AGENCY HAS TAKEN THE FOLLOWING CORRECTIVE ACTION MEASURES:

1. AGENCY AMENDED GRIEVANCE POLICY IDS-006 WHICH MANDATES GRIEVANCE FORMS BE LOCATED IN EACH OF THE RESIDENTIAL DAY ROOMS NEAR THE GRIEVANCE BOXES. THE POLICY INCLUDES SPECIFIC PROCEDURES RESIDENTS ARE TO USE WHEN SUBMITTING THE GRIEVANCE BY PLACING COMPLETED GRIEVANCES IN THE GRIEVANCE LOCK-BOX LOCATED WITHIN THE RESIDENTIAL DAY ROOM. ACCESS TO THE LOCK-BOX IS RESTRICTED TO THE FACILITY CORRECTIONAL SUPERVISOR AND FACILITY CORRECTIONAL DIRECTOR.
2. ON 3/28/17, THE AGENCY FACILITIES DIRECTOR CONDUCTED A HOUSE MEETING IN EACH FACILITY WITH RESIDENTS TO COMMUNICATE THE GRIEVANCE PROCEDURES WHICH ALLOWS RESIDENTS TO RETRIEVE AND SUBMIT GRIEVANCES WITHOUT STAFF INTERVENTION.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.252

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.253(a) – AGENCY MEETS PREA STANDARDS BY PROVIDING RESIDENTS BROCHURES IN BOTH ENGLISH & SPANISH AT INTAKE FOR EFFECTIVE COMMUNICATION, WHICH PROVIDES TOLL FREE ACCESS NUMBERS FOR ACCESS TO OUTSIDE ADVOCATES FOR EMOTIONAL SUPPORT. PREA POSTERS IN BOTH ENGLISH & SPANISH PROVIDE SAME SERVICE & LOCATED IN THE DAY ROOM, BEHIND DOOR OF EACH INDIVIDUAL RESIDENTIAL HOUSING ROOMS & ADMINISTRATIVE OFFICES, CLASSROOMS, COUSELOR OFFICES AND DINING FACILITIES, ACCESSIBLE TO RESIDENTS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS VERIFY AGENCY'S COMMITMENT TO PROVIDE RESIDENTS WITH ACCESS OUTSIDE VICTIM ADVOCATES FOR EMOTIONAL SUPPORT.

115.253(b) – POLICY PREA-005 MANDATES FACILITY INFORMS RESIDENT OF MANDATORY REPORTING RULES GOVERNING CONFIDENTIALITY REGARDING DISCLOSURES OF SEXUAL ABUSE TO OUTSIDE VICTIM ADVOCATES. THIS INFORMATION IS PROVIDED ON PREA POSTERS, AND PROVIDED IN THE RESIDENT BROCHURES.

115.253(c) – AGENCY HAS SECURED AN MOU WITH TESSA TO PROVIDE EMOTIONAL SUPPORT SERVICES.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.253

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.245(a) – AGENCY DISPLAYS METHOD FOR 3RD PARTY REPORTING ON AGENCY WEBSITE WHICH IS ACCESSIBLE TO THE PUBLIC. AGENCY MEETS PREA STANDARD 115.254.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.254

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.261(a) - POLICY PREA-003 MANDATES ALL STAFF TO REPORT IMMEDIATELY ANY KNOWLEDGE, SUSPICION OR INFORMATION REGARDING AN INCIDENT OF SEXUAL ABUSE/HARASSMENT. INTERVIEW WITH RANDOM SAMPLE OF 15 STAFF VERIFIES THEIR DUTY TO REPORT AND KNOWLEDGE AND APPLICATION OF THE PREA STANDARD.

115.261(b) - POLICY PREA-003 MEETS PREA STANDARD NARRATIVE PROHIBITING STAFF FROM REVEALING ANY INFORMATION RELATED TO SEXUAL ABUSE REPORT TO ONLY NEED TO KNOW. INTERVIEW WITIH RANDOM SAMPLE OF STAFF VERIFIES THEIR KNOWLEDGE AND APPLICATION OF THE PREA STANDARD. STAFF INDICATE SHARING OF INFORMATION IS ON NEED TO KNOW BASIS AND PROVIDED ONLY TO INVESTIGATORS & ADMINISTRATIVE STAFF.

115.261(c) - POLICY PREA-003 PROVIDES NARRATIVE WHICH MEETS THIS STANDARD. AGENCY PROVIDED AUDITOR WITH A RANDOM SAMPLE OF 30 RESIDENT DISCLOSURE DOCUMENTED STATEMENTS IN WHICH MEDICAL AND MENTAL HEALTH PRACTITIONERS OUTLINED THE LIMITS OF CONFIDENTIALITY AND DUTY TO REPORT BEFORE INITIATING SERVICES WITH RESIDENTS. BOTH RESIDENTS AND STAFF SIGNED AND DATED THE FORMS. INTERVIEW WITH

MENTAL HEALTH STAFF INDICATES THEIR ADDITIONAL REQUIRED TRAINING FOR THEIR PROFESSION ALSO MANDATES DUTY TO INFORM, DUTY TO REPORT & INFORMING CLIENT THE LIMITATIONS OF CONFIDENTIALITY AT INITIATION OF SERVICES. MENTAL HEALTH STAFF ARE REQUIRED TO PROVIDE A DISCLOSURE STATEMENT TO RESIDENTS PRIOR TO PROVIDING SERVICES WHICH OUTLINES THEIR LIMITS OF CONFIDENTIALITY AND DUTY TO REPORT.

115.261(d) - POLICY PREA-003 PROVIDES PROTOCOL FOR VICTIM UNDER AGE OF 18 & VULNERABLE ADULT. NO JUVENILE UNDER THE AGE OF 18 YEARS ARE HOUSED AT COMCOR INC. PER PREA COORDINATOR & DIRECTOR. SHOULD THIS OCCUR BOTH VICTIM TYPES ARE INVESTIGATED BY CSPD AS A CRIMINAL MATTER. UNDER 18 VICTIM IS ALSO REFERRED TO CPS FOR FOLLOWUP.

115.261(e) - POLICY PREA-003 MANDATES FACILITY REPORTS ALL ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT INCLUDING 3RD PARTY AND ANNONYMOUS REPORTS TO FACILITY'S DESIGNATED INVESTIGATORS. INTERVIEW WITH INVESTIGATIVE STAFF INDICATES THEY WILL INVESTIGATE ALLEGATIONS IMMEDIATELY. SHOULD THE INVESTIGATION DETERMINE THE ABUSE IS CRIMINAL IN NATURE, THE CASE IS REFERRED TO CSPD FOR INVESTIGATION & COMCOR INC. INVESTIGATORS ASSIST WHEN REQUESTED & ARE KEPT APPRISED OF THE INVESTIGATION STATUS PER MOU WITH CSPD.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.261

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.262(a) - POLICY PREA-003 MANDATES STAFF TAKE IMMEDIATE ACTION WHEN AGENCY LEARNS RESIDENT IS OF IMMINENT SEXUAL ABUSE. INTERVIEW WITH AGENCY HEAD, DIRECTOR & RANDOM SAMPLE OF STAFF VERIFY COMPLIANCE WITH AGENCY POLICY, MEETING STANDARD MANDATE. METHODS USED TO PROTECT RESIDENT VICTIMS OF IMMINENT SEXUAL ABUSE IS REHOUSING WITHIN THE SAME FACILITY WITH A NO-CONTACT CONTRACT, REHOUSING PERPETRATOR IN A SEPARATE FACILITY TO INCLUDE A NO-CONTACT CONTRACT, AND HAVING PERPETRATOR REMOVED FROM THE AGENCY ALTOGETHER.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.262

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.263(a) – POLICY PREA-003 MANDATES AGENCY TO TAKE PROMPT ACTION TO NOTIFY HEAD OF FACILITY BY SENIOR PROGRAM MANAGER WHERE SEXUAL ABUSE IS ALLEGED TO OCCURRED. AGENCY IS MANDATED TO NOTIFY THE FACILITY WITHIN 72 HOURS OF RECEIVING ALLEGATION. OVER PAST 12 MONTHS, 1 ALLEGATION OF RESIDENT ABUSE WHILE CONFINED AT ANOTHER FACILITY HAD BEEN RECEIVED REGARDING DIVERSION FACILITY RESIDENTS. COMCOR STAFF IMMEDIATELY INITIATED CONTACT WITH THE PREVIOUS FACILITY AND FOLLOWED THE INVESTIGATIONS. CLIENT WAS OFFERED MENTAL HEALTH TREATMENT. CASE INVESTIGATION IS STILL OPEN AND ONGOING.

115.263(b) – PER POLICY PREA-003, SENIOR PROGRAM MANAGER IS MANDATED TO NOTIFY THE FACILITY WHERE THE INCIDENT OCCURRED WITHIN 72 HOURS OF RECEIVING ALLEGATION.

115.263(c) – PREA POLICY PREA-003 MANDATES FORMER FACILITY WILL BE PROMPTLY NOTIFIED BY SENIOR PROGRAM MANAGER WITHIN 72 HOURS BY AGENCY HEAD PER POLICY. ONE RESIDENT OF DIVERSION FACILITY ALLEGED RESIDENT ABUSE WHILE CONFINED AT ANOTHER FACILITY. DOCUMENTATION FOR THE INVESTIGATION WAS PROVIDED TO AUDITOR WHICH VERIFIED AGENCY'S COMPLIANCE WITH STANDARD PROVISION 115.263(c).

115.263(d) – POLICY PREA-003 MANDATES THAT UPON RECIEPT OF NOTIFICATION THAT SEX ABUSE ALLEGATION HAS OCCURRED, FACILITY HEAD OR AGENCY OFFICE ENSURES ALLEGATION OF SEXUAL ABUSE IS INVESTIGATED ACCORDING TO STANDARD 115.263. INTERVIEW WITH AGENCY HEAD & DIRECTOR VERIFIES COMCOR INC. COMMITMENT TO THIS STANDARD. ONE ALLEGATION OF SEXUAL ABUSE WAS SUBMITTED TO COMCOR INC FROM ANOTHER FACILITY IN 2016, ALLEGING SEXUAL ABUSE OCCURRED IN THE ROBERTS ROAD FACILITY WHILE RESIDENT WAS HOUSED THERE. INVESTIGATIVE STAFF IMMEDIATELY INITIATED AN INVESTIGATION SAME DAY AND FOUND THE ALLEGATION TO BE UNFOUNDED BASED UPON DOCUMENTARY AND ELECTRONIC EVIDENCE.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.263

Standard 115.264 Staff first responder duties

■ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.264(a) – POLICY PREA-004 PROVIDES FOR 1ST RESPONDER RESPONSIBILITIES IN RESPONSE TO AN ALLEGATION OF SEXUAL ABUSE. INTERVIEW WITH STAFF & NON SECURITY 1ST RESPONDER STAFF INDICATE THEY HAVE ALL RECEIVED TRAINING ON THE PROTOCOL AND EXHIBIT CRITERIA OUTLINED IN THE STANDARD. REVIEW OF INVESTIGATIVE RECORDS VERIFIES AGENCY'S RESPONSE TO ALLEGATIONS OF SEXUAL ABUSE. EACH INTERVIEWED STAFF MEMBER WAS IN POSSESSION OF THEIR 1ST RESPONDER CARDS IN THE EVENT OF AN ALLEGATION OF SEXUAL ABUSE. THIS EXTRA STEP ENSURES STAFF FOLLOW THE AGENCY 1ST RESPONDER PROTOCOL AS TRAINED AND **EXCEEDS** THIS STANDARD PROVISION. OF THE 7 ALLEGATIONS OF SEXUAL ABUSE ONLY ONE RESIDENT WAS ALLEGED TO BE SEXUALLY ABUSED WITHIN A TIME PERIOD THAT STILL ALLOWED FOR THE COLLECTION OF PHYSICAL EVIDENCE. AGENCY PROVIDES ALL STAFF WITH IMMEDIATE RESPONSE PROCEDURE CARDS TO BE CARRIED ON THEIR PERSON WHEN ON DUTY TO PROVIDE SWIFT & EFFICIENT RESPONSE TO ALLEGATIONS OF SEXUAL ABUSE.

115.264(b) – RANDOM SAMPLE OF STAFF AND NON-SECURITY STAFF MEMBERS WERE INTERVIEWED & RESPONDED APPROPRIATELY WITH REGARDS TO ENSURING VICTIM & PERPETRATOR NOT TAKE ANY ACTIONS WHICH COULD DESTROY EVIDENCE BY EMPLOYING PROTOCOLS LEARNED DURING TRAINING. POLICY PREA-004 PROVIDES PROTOCOL COMPLIANT WITH STANDARD 115.264. OF ALL 7 ALLEGATIONS OF SEXUAL ABUSE, ONE OF THE INSTANCES OCCURRED WITHIN TIMEFRAME WHERE 1ST RESPONDERS EXERCISED RESPONSE PROTOCOL AS OUTLINED IN PREA-004 POLICY OR STANDARD PROVISION 115.264(b).

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY EXCEEDS STANDARD 115.264

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.265(a) - INTERVIEW WITH DIRECTOR INDICATES AGENCY HAS POLICY WHICH PROVIDES INSTITUTIONAL PROTOCOLS TO COORDINATE ACTIONS IN RESPONSE TO SEXUAL ABUSE AMONG STAFF, 1ST RESPONDERS, MEDICAL AND MENTAL HEALTH PRACTITIONERS, INVESTIGATORS, AND FACILITY LEADERSHIP. REVIEW OF POLICY PREA-004 IDENTIFIES INSTITUTIONAL PLAN IS SPECIFIC TO DIVERSION FACILITY. THE PROTOCOL IDENTIFIES ACTIONS TAKEN BY 1ST RESPONDERS, SUPERVISORS, PREA MANAGER, EXECUTIVE DIRECTOR & PREA COORDINATOR, AGENCY INVESTIGATIVE STAFF FOR ADMINISTRATIVE INVESTIGATION, COLORADO SPRINGS PD FOR CRIMINAL INVESTIGATION, SAFE/SANE FOR FORENSIC EVALUATION AND RAPE CRISIS CENTER FOR EMOTIONAL SUPPORT. POLICY PREA-005 MANDATES SPECIFIC ACTIONS TAKEN BY MEDICAL STAFF (SAFE/SANE) AND MEDICAL PRACTITIONERS, RAPE CRISIS CENTER VICTIM ADVOCATE, OTHER OUTSIDE VICTIM ADVOCATE, STAFF MEMBER VICTIM ADVOCATE, MEDICAL AND MENTAL HEALTH EVALUATION.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.265

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

█ Not Applicable

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.

115.266(a) – N/A - STANDARD PROVISION NOT APPLICABLE TO THIS AGENCY. COM COR INC IS NOT SUBJECT OT ANY COLLECTIVE BARGAINING AGREEMENT.
115.266(b) – N/A - STANDARD PROVISION NOT APPLICABLE TO THIS AGENCY PER DOJ.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.267(a) – POLICY PREA-013 MANDATES COMCOR TO EMPLOY MULTIPLE PROTECTION MEASURES 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. PREA COORDINATOR IS DESIGNATED AS RESPONSIBLE TO MONITOR POSSIBLE RETALIATION FOR COM COR INC.
115.267(b) – POLICY PREA-013 MANDATES AGENCY EMPLOY MULTIPLE PROTECTION MEASURES TO PROTECT BOTH RESIDENTS AND STAFF WHO FEAR RETALIATION FOR REPORTING SEXUAL ABUSE/HARASSMENT OR FOR COOPERATING WITH INVESTIGATIONS. INTERVIEW WITH AGENCY HEAD, DIRECTOR, PREA COORDINATOR & RESIDENTS WHO REPORTED SEX ABUSE ALL AGREE AGENCY HAS EMPLOYED PROTECTION MEASURES TO PROVIDE A SAFE ENVIRONMENT FOR RESIDENTS. HOUSING CHANGES, TRANFERS FOR VICTIMS OR ABUSERS & REMOVAL OF ALLEGED STAFF OR RESIDENT ABUSERS HAVE BEEN EMPLOYED BY AGENCY. MONTORING & PROVISION OF EMOTIONAL SUPPORT IS PROVIDED FOR VICTIMS OF SEX ABUSE & THOSE WHO FEAR RETALIATION FOR REPORTING SEX ABUSE. OR COOPERATING WITH INVESTIGATIONS.
115.267(c) – INTERVIEW WITH DIRECTOR & PREA COORDINATOR DETERMINES AGENCY MONITORS CONDUCT & TREATMENT OF RESIDENTS OR STAFF WHO WERE REPORTED TO SUFFER SEX ABUSE PER POLICY PREA-013. PREA COORDINATOR INDICATES THE MONITORING MAY CONTINUE PAST THE 90 DAY PERIOD SHOULD THERE BE A CONTINUING NEED. OVER THE PAST 12 MONTHS, NO RESIDENT HAS MADE AN ALLEGATION OF RETALIATION.
115.267(d) – POLICY PREA-013 MANDATES MONITORING TO INCLUDE PERIODIC STATUS CHECKES. PREA COORDINATOR

INDICATES THE MONITORING ARE FACE TO FACE AND MAY CONTINUE PAST THE 90 DAY PERIOD SHOULD THERE BE A CONTINUING NEED.
115.267(e) – POLICY PREA-013 INCORPORATES NARRATIVE COMPLIANT WITH THIS STANDARD. INTERVIEW WITH DIRECTOR VERIFIES AGENCY'S COMMITMENT TO PROTECT INDIVIDUALS WHO FEAR RETALIATION.
115.267(f) – N/A – STANDARD PROVISION NOT APPLICABLE TO THIS AGENCY PER DOJ.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.267

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.271(a) – POLICY PREA-007 PROVIDES PROTOCOL FOR CRIMINAL & ADMINISTRATIVE INVESTIGATIONS. 7 INVESTIGATIVE REPORTS HAVE BEEN REVIEWED BY AUDITOR AND ALL WERE INVESTIGATED PROMPTLY AFTER AGENCY WAS NOTIFIED OF THE MISCONDUCT. ALL 7 INVESTIGATIONS INVOLVED INMATE ON INMATE SEXUAL MISCONDUCT. 6 ALLEGATIONS WERE INVESTIGATED AS SEXUAL ABUSE CASES AND 1 WAS INVESTIGATED AS A SEXUAL HARASSMENT CASE. 2 INVESTIGATIONS ARE STILL ONGOING. OF THE REMAINING 5 CASES, 2 ALLEGATIONS WERE UNSUBSTANTIATED AND 3 ALLEGATIONS WERE SUBSTANTIATED. INTERVIEW WITH INVESTIGATIVE STAFF INDICATE COMCOR INC. INVESTIGATES ONLY ADMINISTRATIVE SEX ABUSE INVESTIGATIONS, COLORADO SPRINGS PD IS RESPONSIBLE FOR THE CRIMINAL INVESTIGATIONS AS OUTLINED IN POLICY.
115.271(b) – ALL 4 COMCOR INVESTIGATORS HAVE BEEN TRAINED THROUGH THE NIC SEX ABUSE INVESTIGATION IN A CORRECTIONAL SETTING TRAINING. AUDITOR HAS INTERVIEWED INVESTIGATIVE STAFF TO VERIFY THEIR KNOWLEDGE & TRAINING AS MANDATED BY THIS STANDARD. TRAINING RECORDS ALSO VERIFY TRAINING HAS BEEN COMPLETED PER STANDARD 115.271.
115.271(c) – POLICY PREA-007 DICTATES COLORADO SRINGS PD COLLECTS PHYSICAL & DNA EVIDENCE. AGENCY STAFF SECURES SCENE FOR COLLECTION OF EVIDENCE. AGENCY STAFF WILL COLLECT ELECTRONIC EVIDENCE & INTERVIEW WITNESSES, VICTIM & PERPETRATORS. INVESTIGATORS PRESERVE EVIDENCE FOR CSPD TO COLLECT FOR CRIMINAL INVESTIGATIONS PER INVESTIGATIVE STAFF INTERVIEWS AND PREA-007 POLICY. INVESTIGATORS ENSURE PHYSICAL EVIDENCE IS SECURED, SCENE IS SECURED AND VICTIMS & PERPETRATORS ARE NOT ALLOWED TO DESTROY ANY EVIDENCE ON THEIR PERSON VIA BRUSHING TEETH, SHOWERING, CHANGING OF CLOTHES, EATING, ETC. AGENCY PROVIDED AUDITOR WITH CSPD MOU.
115.271(d) – POLICY PREA-007 MANDATES COMCOR INVESTIGATORS WILL NOT CONDUCT COMPELLED INTERVIEWS AS PART OF ANY CRIMINAL INVESTIGATION. COMPELLED INTERVIEWS SHOULD ONLY BE CONDUCTED BY LAW ENFORCEMENT PERSONNEL DURING THE COURSE OF A CRIMINAL INVESTIGATION AND AFTER CONSULTING A PROSECUTING ATTORNEY. INTERVIEWS WITH INVESTIGATIVE STAFF INDICATE COMPELLED INTERVIEWS ARE NOT CONDUCTED WITHOUT DIRECTION FROM COLORADO SPRINGS PD AND THE DA's OFFICE.
115.271(e) – POLICY PREA-007 INDICATE 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 A RESIDENT OR STAFF. INTERVIEW WITH INVESTIGATIVE STAFF INDICATE THE CHARACTER OF THE INVESTIGATION DETERMINES CREDIBILITY. EVERYONE IS DEEMED CREDIBLE UNLESS THE INVESTIGATION EVIDENCE AND/OR

FINDINGS DEEM OTHERWISE.

115.271(f) – POLICY PREA-007 MANDATES ALL INVESTIGATIONS ARE DOCUMENTED IN WRITTEN REPORTS WHICH INCLUDE SPECIFIC INVESTIGATIVE REPORTS, DETERMINATIONS & FINDINGS PER INTERVIEW WITH INVESTIGATIVE STAFF & REVIEW OF INVESTIGATIVE REPORTS.

115.271(g) – POLICY PREA-007 INDICATES ALL INVESTIGATIONS ARE DOCUMENTED IN WRITTEN REPORTS WHICH INCLUDE SPECIFIC INVESTIGATIVE REPORTS & FINDINGS PER INTERVIEW WITH INVESTIGATIVE STAFF, INTERVIEWS, CREDIBLE/PHYSICAL EVIDENCE, DETERMINATIONS AND FINDINGS.

115.271(h) – INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES COMPLIANCE WITH THIS STANDARD. ALL ALLLEGATIONS WHICH APPEAR TO BE CRIMINAL IN NATURE ARE REFERRED TO CSPD FOR INVESTIGATION. REVIEW OF THE 1 CRIMINAL INVESTIGATION REFERRAL CONDUCTED BY AUDITOR, IS STILL PENDING AS CSPD HAS NOT MADE A FINDING AS OF YET. VICTIM OFFERRED AND ACCEPTED 90-DAY MONITORING AND MENTAL HEALTH COUNSELING AT NO COST. CASE REMAINS OPEN WITH CSPD.

115.271(I) – POLICY PREA-007 & PREA-015 INDICATE ALL WRITTEN REPORTS REFERENCED IN STANDARD 115.271 WILL BE RETAINED BY THE AGENCY FOR AS LONG AS ALLEGED ABUSER IS INCARCERATED OR EMPLOYED BY THE AGENCY, PLUS 5 YEARS.

115.271(j) – POLICY PREA-007 MANDATES THE DEPARTURE OF THE ALLEGED ABUSER OR VICTIM FROM THE APPOINTMENT OR CONTROL FROM THE FACILITY OR AGENCY SHALL NOT PROVIDE THE BASIS FOR TERMINATION OF INVESTIGATION. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES POLICY COMPLIANCE.

115.271(k) – N/A - THIS STANDARD DOES NOT APPLY TO THIS AGENCY PER DOJ.

115.271(l) – POLICY PREA-007 MANDATES THAT 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. INTERVIEWS WITH DIRECTOR, PREA COORDINATOR AND INVESTIGATIVE STAFF VERIFIES POLICY COMPLIANCE. INVESTIGATIVE STAFF INDICATES THERE IS COMMUNICATION BETWEEN COLORADO SPRINGS PD INVESTIGATORS REGARDING THE STATUS OF CASES ON AN ONGOING BASES. INVESTIGATORS ALSO HAVE COMMUNICATION WITH THE DA'S OFFICE REGARDING STATUS OF CASES AND ASSIST BOTH WHENEVER ASSISTANCE IS REQUESTED OR NEEDED RELATED TO AN INVESTIGATION.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.271

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.272(a) - POLICY PREA-007 AND INTERVIEW WITH INVESTIGATIVE STAFF INDICATE NO STANDARD HIGHER THAN PREPONDERANCE OF THE EVIDENCE IS UTILIZED IN DETERMINING WHETHER ALLEGATIONS OF SEXUAL ABUSE OR SEXUAL HARASSMENT ARE SUBSTANTIANTED**.** INTERVIEW WITH AGENCY INVESTIGATORS VERIFY PRACTICE OF AGENCY POLICY PRE 007 WHICH MEETS THE PREA STANDARD.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.272

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.273(a) – POLICY PREA-017 MANDATES AGENCY INFORMS RESIDENT VICTIMS OF THE OUTCOME OF AN SEXUAL ABUSE INVESTIGATIONS. IN THE PAST 12 MONTHS THERE HAVE BEEN 7 ALLEGATIONS OF SEXUAL ABUSE COMPLETED BY FACILITY. 1 CASE ORIGINATED IN A PREVIOUS FACILITY, 5 WERE INVESTIGATED BY COMCOR SPECIAL INVESTIGATORS AS AN ADMINISTRATIVE INVESTIGATION AND 1 WAS INVESTIGATED BY CSPD AS A CRIMINIAL INVESTIGATION. ALL IDENTIFIED INVESTIGATIONS WERE PROVIDED TO AUDITOR AND 5 NOTIFICATION DOCUMENTATIONS WERE WRITTEN AT THE CONCLUSION OF THE INVESTIGATIONS. 2 INVESTIGATIONS ARE ONGOING. NOTIFICATIONS WERE SIGNED BY THE VICTIM UNLESS THE VICTIM LEFT COMCOR PRIOR TO THE CONCLUSION OF THE INVESTIGATION. INTERVIEWS WITH THE DIRECTOR AND INVESTIGATIVE STAFF INDICATE COMCOR DEDICATION TO BEING COMPLIANT WITH THIS STANDARD. NONE OF THE RESIDENTS WHO REPORTED A SEXUAL ABUSE WERE AVAILABLE FOR INTERVIEW AS THEY HAVE LEFT COMCOR.

115.273(b) – PREA-007 MANDATES IF OUTSIDE AGENCY CONDUCTS SEXUAL ABUSE INVESTIGATIONS THE AGENCY REQUESTS RELEVANT INFORMATION FROM THE INVESTIGATIVE AGENCY TO INFORM THE RESIDENT. NO COMPLETED SEXUAL ABUSE INVESTIGATIONS CONDUCTED BY AN OUTSIDE AGENCY WITHIN PAST 12 MONTHS. ONE INVESTIGATION BY CSPD IS DEEMED OPEN AND COMCOR INC. IS UNABLE TO OBTAIN THE POLICE REPORT AT THIS TIME, VERIFIED BY AUDITOR THROUGH WRITTEN DOCUMENTATION FROM CSPD.

115.273(c) – POLICY PREA-017 MANDATES THAT FOLLOWING A RESIDENTIAL CLIENT'S ALLEGATION THAT A COMCOR STAFF MEMBER COMMITTED SEXUAL ABUSE AGAINST THE CLIENT, COMCOR WILL INFORM THE RESIDENTIAL CLIENT (UNLESS THE ALLEGATION WAS DETERMINED TO BE UNFOUNDED) OF THE FOLLOWING EVENTS:

1. IF THE STAFF MEMBER IS NO LONGER ASSIGNED TO THE RESIDENTIAL FACILITY WHERE THE CLIENT RESIDES
2. IF THE STAFF MEMBER IS NO LONGER A COMCOR EMPLOYEE
3. IF COMCOR LEARNS THAT THE STAFF MEMBER WAS INDICTED ON A CHARGE RELATED TO SEXUAL ABUSE WHILE AT COMCOR
4. IF COMCOR LEARNS THAT THE STAFF MEMBER WAS CONVICTED ON A CHARGE RELATED TO SEXUAL ABUSE WHILE AT COMCOR.

115.273(d) – POLICY PREA-017 MANDATES THAT FOLLOWING A RESIDENTIAL CLIENT'S ALLEGATION THAT HE OR SHE WAS SEXUALLY ABUSED BY ANOTHER CLIENT, COMCOR WILL INFORM THE ALLEGED VICTIM WHENEVER:

1. COMCOR LEARNS THAT THE ALLEGED ABUSER WAS INDICTED ON A CHARGE RELATED TO SEXUAL ABUSE WHILE AT COMCOR
2. COMCOR LEARNS THAT THE ALLEGED ABUSER WAS CONVICTED ON A CHARGE RELATED TO SEXUAL ABUSE WHILE AT COMCOR OF THE 5 RESIDENT ON RESIDENT ALLEGATIONS OF SEXUAL ABUSE, NONE OF THE ABUSERS WERE INDICTED OR CONVICTED OF SEXUAL MISCONDUCT.

115.273(e) – REVIEW OF ALL 7 INVESTIGATIONS DETERMINED THE 5 NOTIFICATIONS WERE PROVIDED TO VICTIMS IN WRITING, HOWEVER ALL 5 WERE EITHER TERMINATED FROM THE COMCOR INC PROGRAM AND ONE ESCAPED FROM THE PROGRAM. THE DOCUMENTATION WAS PROVIDED TO THEIR RESPECTIVE OVERSIGHT AGENCIES. TWO OF THE INVESTIGATIONS ARE STILL ONGOING.

115.273(f) – N/A – STANDARD PROVISION IS NOT APPLICABLE TO AGENCY PER DOJ.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.273

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.276(a) – POLICY PREA-014 MANDATES TERMINATION SHALL BE THE PRESUMPTIVE DISCIPLINARY SANCTION FOR STAFF WHO HAVE ENGAGED IN SEXUAL ABUSE. AGENCY AND INVESTIGATIVE REPORTS VERIFIES NO STAFF MEMBER WAS TERMINATED FROM THE FACILITY DUE TO VIOLATION OF SEXUAL ABUSE/HARASSMENT POLICY.
115.276(b) – POLICY PREA-014 MANDATES TERMINATION SHALL BE THE PRESUMPTIVE DISCIPLINARY SANCTION FOR STAFF WHO HAVE ENGAGED IN SEXUAL ABUSE. AGENCY AND INVESTIGATIVE REPORTS VERIFIES NO STAFF MEMBER WAS TERMINATED FROM THE FACILITY OVER THE PAST 12 MONTHS.
115.276(c) – POLICY PREA-014 PROVIDES MANDATES DISCIPLINARY SANCTIONS FOR VIOLATIONS OF AGENCY POLICIES RELATING TO SEXUAL ABUSE OR SEXUAL HARASSMENT (OTHER THAN ACTUALLY ENGAGING IN SEXUAL ABUSE) SHALL BE COMMENSURATE WITH THE NATURE AND CIRCUMSTANCES OF THE ACTS COMMITTED, THE STAFF MEMBER'S DISCIPLINARY HISTORY, AND THE SANCTIONS IMPOSED FOR COMPARABLE OFFENSES BY OTHER STAFF WITH SIMILAR HISTORIES. NO RECORD OF DISCIPLINARY SANCTIONS, SHORT OF TERMINATION, AGAINST STAFF FOR SEX ABUSE OR SEX HARASSMENT OVER PAST 12 MONTHS.
115.276(d) – POLICY PREA-014 MANDATES ALL TERMINATIONS FOR VIOLATIONS OF AGENCY SEXUAL ABUSE OR SEXUAL HARASSMENT POLICIES, OR RESIGNATIONS BY STAFF WHO WOULD HAVE BEEN TERMINATED IF NOT FOR THEIR RESIGNATION, SHALL BE REPORTED TO LAW ENFORCEMENT AGENCIES, UNLESS THE ACTIVITY WAS CLEARLY NOT CRIMINAL, AND TO ANY LICENSING BODIES. STAFF MEMBER WHO WAS TERMINATED FOLLOWING INVESTIGATION THAT SUBSTANTIATED A STAFF SEXUAL MISCONDUCT ALLEGATION ON A RESIDENT WAS REFERRED TO LOCAL LAW ENFORCEMENT FOLLOWING SAID TERMINATION AS VERIFIED VIA INVESTIGATIVE SUMMARY RECORDS REVIEW.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.276

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.277(a) – DIVERSION FACILITY HAS 4 CONTRACTORS AND 1 VOLUNTEER ASSIGNED. NO CONTRACTORS/VOLUNTEERS REPORTED TO LAW ENFORCEMENT IN PAST 12 MONTHS FOR ENGAGING IN SEX ABUSE OF RESIDENTS. POLICY PREA 013 INCLUDES NARRATIVE WHICH IS COMPLIANT WITH STANDARD 115.277(a).

115.277(b) – POLICY PREA 013 MANDATES ANY CONTRACTOR OR VOLUNTEER WHO ENGAGES IN SEXUAL ABUSE SHALL BE PROHIBITED FROM CONTACT WITH CLIENTS AND SHALL BE REPORTED TO LAW ENFORCEMENT AGENCIES, UNLESS THE ACTIVITY WAS CLEARLY NOT CRIMINAL, AND TO RELEVANT LICENSING BODIES. THE FACILITY SHALL TAKE APPROPRIATE REMEDIAL MEASURES, AND SHALL CONSIDER WHETHER TO PROHIBIT FURTHER CONTACT WITH CLIENTS, IN THE CASE OF ANY OTHER VIOLATION OF AGENCY SEXUAL ABUSE OR SEXUAL HARASSMENT POLICIES BY A CONTRACTOR OR VOLUNTEER.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.277

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.278(a) – POLICY PREA-014 MANDATES CLIENTS SHALL BE SUBJECT TO DISCIPLINARY SANCTIONS PURSUANT TO A FORMAL DISCIPLINARY PROCESS FOLLOWING AN ADMINISTRATIVE FINDING THAT THE CLIENT ENGAGED IN CLIENT-ON-CLIENT SEXUAL ABUSE OR FOLLOWING A CRIMINAL FINDING OF GUILT FOR CLIENT-ON-CLIENT SEXUAL ABUSE. REVIEW OF INVESTIGATIVE FILES INDICATE 5 RESIDENT ON RESIDENT ADMINISTRATIVE SEX ABUSE INVESTIGATIONS ALL OF WHICH WERE UNSUBSTANTIATED OR UNFOUNDED, 1 CRIMINAL SEX ABUSE INVESTIGATION WHICH WAS UNSUBSTANTIATED & REFERRED TO DA FOR PROSECUTION, AND 1 ALLEGATIONS OF SEXUAL ABUSE WHICH OCCURRED IN A PREVIOUS FACILITY.

115.278(b) – POLICY PREA-014 MANDATES SANCTIONS SHALL BE COMMENSURATE WITH THE NATURE AND CIRCUMSTANCES OF THE ABUSE COMMITTED.

115.278(c) – REVIEW OF POLICY PREA-014 & INTERVIEW WITH DIRECTOR INDICATES ADMINISTRATION FOLLOWS POLICY WHICH IS COMPLIANT WITH STANDARD PROVISION.

115.278(d) – INTERVIEW WITH MENTAL HEALTH STAFF INDICATES ABUSERS ARE COUNSELED OR REFERRED TO OUTSIDE SERVICES TO ADDRESS THEIR ISSUES.

115.278(e) – POLICY PREA-014 MANDATES AGENCY MAY DISCIPLINE A RESIDENT FOR SEXUAL CONTACT WITH STAFF UPON A FINDING THAT THE STAFF MEMBER DID NOT CONSENT TO SUCH CONTACT. THERE IS NO RECORD OF DISCIPLINARIES AGAINST A RESIDENT WHO HAD SEXUAL CONTACT WITH STAFF.

115.278(f) – AGENCY PROHIBITS DISCIPLINARY ACTION AGAINST RESIDENT WHO MADE SEX ABUSE REPORT IN GOOD FAITH PER POLICY PREA-014.

115.278(g) – POLICY PREA-014 PROHIBITS ALL SEXUAL ACTIVITY BETWEEN RESIDENTS. THE AGENCY CONSITUTES SEXUAL ABUSE ONLY IF IT DETERMINES THAT THE ACTIVITY IS COERCED.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.278

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.282(a) – RESIDENT VICITMS ARE PROVIDED TIMELY UNIMPEDED ACCESS TO EMERGENCY MEDICAL TREATMENT & CRISIS INTERVENTION SERVICES PER POLICY PREA-005, COMPLIANT WITH STANDARD 115.282(a). INTERVIEW WITH MENTAL HEALTH STAFF VERIFIES POLICY. REVIEW OF INVESTIGATIVE REPORT VERIFIES COMCOM INC STAFF PROVIDED EMOTIONAL, MEDICAL AND MENTAL HEALTH SUPPORT IMMEDIATELY UPON NOTIFICATION OF SEXUAL ABUSE OCCURRENCE.

115.282(b) – INTERVIEW WITH 1ST RESPONDERS INDICATE THEY ARE TRAINED TO TAKE PRELIMINARY STEPS TO PROTECT THE VICITM & NOTIFY SUPERVISOR SO APPROPRIATE MENTAL HEALTH & MEDICAL HEALTH PRACTIONERS ARE NOTIFIED. PROBING QUESTIONS FROM AUDITOR VERIFIED STAFF KNOWLEDGE AND EDUCATION AS IT RELATES TO 1ST RESPONDER RESPONSIBILITIES.

115.282(c) – INTERVIEW WITH MENTAL HEALTH STAFF INDICATE COMCOR MANDATES ARE COMPLIANT WITH THIS STANDARD. CONTACT WITH SANE NURSE AT MEMORIAL HOSPITAL INDICATE RESIDENT VICTIMS ARE PROVIDED INFORMATION REGARDING EMERGENCY CONTRACEPTION & STD PROPHYLAXIS DURING FORENSIC EXAM & TREATMENT. RESIDENTS WHO REPORTED SEX ABUSE INDICATE THEY WERE OFFERRED SUCH TREATMENT AT BY MEDICAL PRACTITIONERS AT MEMORIAL HOSPITAL.

115.282(d) – POLICY PREA-005 STATES TREATMENT SERVICES ARE PROVIDED TO VICTIM OF SEX ABUSE WITHOUT COST IN ACCORDANCE WITH STANDARD 115.282(d).

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.282

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.283(a) – POLICY PREA-005 MANDATES THE OFFER OF MEDICAL & MENTAL HEALTH EVALUATION TO ALL RESIDENTS WHO HAVE BEEN VICTIMIZED BY SEXUAL ABUSE IN ANY CORRECTIONAL CONFINEMENT SETTING.

115.283(b) – REVIEW OF INVESTIGATIVE REPORTS, INTERVIEW WITH MENTAL HEALTH STAFF & INTERVIEW WITH RESIDENTS WHO REPORTED A SEXUAL ABUSE ALL VERIFY AGENCY'S COMMITMENT TO MANDATE FOLLOWUP TREATMENT AND MONITORING OF VICTIMS WHICH INCLUDES TRANSFER OR PLACEMENT TO OTHER FACILITIES TO ENSURE

SEXUAL SAFETY.

115.283(c) – INTERVIEW WITH MENTAL HEALTH PRACTIONER AND SANE NURSE FROM MEMORIAL HOSPITAL BOTH VERIFY RESIDENTS ARE PROVIDED VICTIMS OF SEX ABUSE MENTAL & MEDICAL HEALTH SERVICES CONSISTENT WITH THE COMMUNITY LEVEL OF CARE. MENTAL HEALTH PRACTIONER INDICATES IF PRACTIONER NOT ON DUTY AT TIME OF INCIDENT, AGENCY HAS MADE CONNECTION WITH MENTAL HEALTH SERVICES WHICH PROVIDES THE SAME LEVEL OF CARE CONSISTENT WITH THE COMMUNITY LEVEL OF CARE.

115.283(d) – N/A – STANDARD PROVISION DOES NOT APPLY TO TRANSITION FACILITY AS IT IS AN ALL MALE FACILITY.

115.283(e) – N/A – STANDARD PROVISION DOES NOT APPLY TO TRANSITION FACILITY AS IT IS AN ALL MALE FACILITY.

115.283(f) – POLICY PREA-005 MANDATES VICTIMS OF SEXUAL ABUSE WHILE INCARCERATED SHALL BE OFFERED STD TESTS. DEMONSTRATION OF POLICY VERIFIED THROUGH INTERVIEWS WITH MENTAL HEALTH STAFF AND SANE/SAFE NURSE AT MEMORIAL HOSPITAL.

115.283(g) – POLICY PREA-005 MANDATES TREATMENT SERVICES WILL BE PROVIDED AT NO COST TO VICTIMS OF SEXUAL ABUSE.

115.283(h) – POLICY PREA-005 NARRATIVE COMPLIANT WITH STANDARD 115.283(h) IN THAT RESIDENT ON RESIDENT ABUSERS ARE OFFERED TREATMENT OF ABUSE HISTORY BY MENTAL HEALTH PRACTITIONSERS WITHIN 60 DAYS OF LEARNING OF SUCH ABUSE HISTORY. INTERVIEW WITH MENTAL HEALTH PRACTIONER INDICATES COMCOR INC. OFFERS THIS TREATMENT IMMEDIATELY UPON LEARNING OF SEX ABUSE HISTORY.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.283

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.286(a) – POLICY EDS-011 MANDATES AGENCY CONDUCT A SEXUAL ABUSE INCIDENT REVIEW AT THE CONCLUSION OF EVERY SEXUAL ABUSE INVESTIGATIONS. 5 INCIDENT REVIEWS OF ALL 7 PREA RELATED INCIDENTS WERE PROVIDED & REVIEWED BY AUDITOR. OF THE 7 SEXUAL ABUSE INCIDENTS, 2 INVESTIGATIONS ARE ONGOING.

115.286(b) – REVIEW OF EACH OF THE 5 INCIDENT REVIEWS OCCURRED WITHIN 30 DAYS OF CONCLUSION OF THE INVESTIGATION.

115.286(c) – PER POLICY IDS-011, EACH OF THE 5 INVESTIGATIVE INCIDENT REVIEWS WERE CONDUCTED BY UPPER LEVEL MANAGEMENT OFFICIALS WITH INPUT FROM SUPERVISIORS, INVESTIGATORS & STAFF MENTAL HEALTH PRACTITIONERS.

115.286(d) – POLICY IDS-011 NARRATIVE INCLUDES CRITERIA OUTLINED IN STANDARD 115.286(d). INTERVIEW WITH DIRECTOR, PREA COORDINATOR AND REPRESENTATIVE OF INCIDENT REVIEW TEAM ALL STATE CRITERIA OUTLINED IN THIS STANDARD IS CONSIDERED WHEN ASSESSING MERITS OF EACH INVESTIGATION AND PREPARING FINDINGS & RECOMMENDATIONS FOR IMPROVEMENT.

115.286(e) – INTERVIEW WITH DIRECTOR INDICATES AGENCY TAKES RECOMMENDATIONS & FINDINGS OF REVIEW TEAM SERIOUSLY & IMPLEMENTS IMPROVEMENT RECOMMENDATIONS. IMPLEMENTATION OF THESE RECOMMENDATIONS ARE IDENTIFIED IN BOTH THE ANNUAL REPORT AND STAFFING PLANS.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.286

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.287(a)/(c) – POLICY PREA-015 AND PREA STATS COLLECTION INSTRUMENT REVIEWED. POLICY MEETS STANDARD 115.287(a)/(c). INCIDENT BASED DATA COLLECTION INSTRUMENT INCLUDES INFORMATION TO ANSWER QUESTIONS FROM THE MOST RECENT VERSION OF THE SURVEY OF SEXUAL VIOLENCE CONDUCTED BY THE DEPARTMENT OF JUSTICE.
115.287(b) – REVIEW OF 2015 ANNUAL REPORT REVIEWED ON COMCOR INC. WEBSITE, VERIFIES AGENCY AGGREGATES INCIDENT BASED DATA ANNUALLY.
115.287(d) – AGGREGATED DATA IS COLLECTED FROM ALL INCIDENT-BASED DOCUMENTS & CATS DATA SYSTEMS PER POLICY PREA-015. REVIEW OF ANNUAL REPORTS VERIFIES PRACTICE.
115.287(e) – N/A - AGENCY DOES NOT CONTRACT FOR THE CONFINEMENT OF IT'S RESIDENTS.
115.287(f) – N/A - DOJ HAS NOT REQUESTED AGENCY DATA.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.287

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.288(a) – IDS-015 PAGE #2 POLICY PREA COMPLIANT. 2015 ANNUAL REPORT INCLUDED IN COM COR INC WEBSITE WITH A COMPARISON OF 2013, 2014 & 2015 DATA. 2015 ANNUAL REPORT PROVIDES CORRECTIVE ACTION TAKEN FOR FACILITIES & AGENCY AS A WHOLE.
115.288(b) – 2015 ANNUAL REPORT INCLUDES THE COMPARISON OF 2013, 2014 & 2015 ANNUAL REPORTS TO INCLUDE CORRECTIVE ACTIONS OF PREVIOUS YEARS.
115.288(c) – INTERVIEW WITH AGENCY HEAD DESIGNEE INDICATES ANNUAL REPORT IS APPROVED AT HIS LEVEL AND MADE AVAILABLE TO THE PUBLIC ON AGENCY WEBSITE. AUDITOR VERIFIED 2015 ANNUAL REPORT ON AGENCY WEBSITE IN THE PREA SECTION.
115.288(d) – REVIEW OF ANNUAL REPORT DETERMINES THERE IS NO INFORMATION WITHIN THE REPORT WHICH WOULD

PRESENT A CLEAR & SPECIFIC THREAT TO THE SAFETY & SECURITY OF THE FACILITY. INTERVIEW WITH PREA COORDNIATOR DETERMINES ANY SUCH INFORMATION OR DATA WOULD BE REDACTED BEFORE BEING MADE AVAILABLE TO THE PUBLIC.

AUDITOR HAS DETERMINED THAT AGENCY IS NOT INCOMPLIANCE WITH STANDARD PROVISION 115.288(b)

CORRECTIVE ACTION:
AGENCY TO IMPLEMENT AND PROVIDE VERIFICATION OF THE FOLLOWING CORRECTIVE ACTIONS:

1. **AGENCY TO UPLOAD 2016 ANNUAL REPORT ON AGENCY WEBSITE WHICH PROVIDES AGGREGATED SEXUAL ABUSE & SEXUAL HARASSMENT DATA TO INCLUDE CORRECTIVE ACTIONS OF PREVIOUS YEARS**

2. **PERSONAL IDENTIFIERS REDACTED**

3. **NARRATIVE WHICH INDICATES THE NATURE OF REDACTED MATERIAL**

CORRECTIVE ACTION TO BE COMPLETED NO LATER THAN 10/5/17

CORRECTIVE ACTION COMPLETION 4/23/17:
AGENCY HAS TAKEN THE FOLLOWING CORRECTIVE ACTION MEASURES:

1. AGENCY PROVIDED AUDITOR WITH COPY OF 2016 ANNUAL REPORT WHICH INCLUDES AGGREGATED SEXUAL ABUSE & SEXUAL HARASSMENT DATA FROM 2014 TO 2016
2. REVIEW OF THE 2016 ANNUAL REPORT INDICATES ALL PERSONAL IDENTIFIERS HAVE BEEN REMOVED FROM THE AGGREGATED DATA.
3. 2016 ANNUAL REPORT INCLUDE DISCLAIMER THAT PERSONAL IDENTIFIERS AND SPECIFIC LOCATIONS WHERE INCIDENTS OF SEXUAL ABUSE AND SEXUAL HARASSMENT OCCURRED HAVE BEEN REDACTED FROM THE REPORT AS INCLUSION WOULD PRESENT A CLEAR AND SPECIFIC THREAT TO THE SAFETY AND SECURITY OF THE FACILITY, STAFF AND RESIDENTS.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.288

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.289(a) – POLICY PREA-015 MANDATES SENSITIVE DATA COLLECTED FOR ANNUAL REPORT IS SECURELY MAINTAINED. INTERVIEW WITH PREA COORDINATOR INDICATES PERSONAL IDENTIFIERS ARE MAINTAINED SECURELY ON A NEED TO KNOW BASIS. PREA COORDINATOR MAINTAINS THE DATA.

115.289(b) – POLICY PREA-015 POLICY MANDATES COMCOR TO MAKE ALL AGGREGATED SEXUAL ABUSE DATA READILY AVAILABLE TO THE PUBLIC AT LEAST ANNUALLY. COMCOR WILL REMOVE ALL PERSONAL IDENTIFIERS BEFORE MAKING AGGREGATED SEXUAL ABUSE DATA PUBLICLY AVAILABLE. ANNUAL REPORT 2015 IS MAINTAINED ON AGENCY WEBSITE, AVAILABLE TO THE PUBLIC, AS VERIFIED BY AUDITOR. DATA MAINTAINED IN ANNUAL REPORT IS AGGEGATED SEX ABUSE DATA FROM FACILITIES UNDER AGENCY CONTROL.

115.289(c) – REVIEW OF 2015 ANNUAL REPORT BY AUDITOR DETERMINES THERE ARE NO PERSONAL IDENTIFIES IN EITHER REPORT & DATA IS AGGREGATED SEXUAL ABUSE DATA.

115.289(d) – POLICY PREA-015 MANDATES COMCOR WILL MAINTAIN SEXUAL ABUSE DATA COLLECTED PURSUANT TO THIS POLICY FOR AT LEAST TEN YEARS AFTER THE DATE OF INITIAL COLLECTION UNLESS FEDERAL, STATE OR LOCAL LAW REQUIRES OTHERWISE.

AUDITOR HAS DETERMINED THAT AGENCY IS NOT INCOMPLIANCE WITH STANDARD PROVISION 115.289(b) & 289(c)

CORRECTIVE ACTION:

AGENCY TO IMPLEMENT AND PROVIDE VERIFICATION OF THE FOLLOWING CORRECTIVE ACTIONS:

1. **AGENCY TO UPLOAD 2016 ANNUAL REPORT ON AGENCY WEBSITE WHICH PROVIDES AGGREGATED SEXUAL ABUSE & SEXUAL HARASSMENT DATA TO INCLUDE CORRECTIVE ACTIONS OF PREVIOUS YEARS**

2. **PERSONAL IDENTIFIERS REDACTED**

3. **NARRATIVE WHICH INDICATES THE NATURE OF REDACTED MATERIAL**

CORRECTIVE ACTION TO BE COMPLETED NO LATER THAN 10/5/17

CORRECTIVE ACTION COMPLETION 4/23/17:

AGENCY HAS TAKEN THE FOLLOWING CORRECTIVE ACTION MEASURES:

1. AGENCY PROVIDED AUDITOR WITH COPY OF 2016 ANNUAL REPORT WHICH INCLUDES AGGREGATED SEXUAL ABUSE & SEXUAL HARASSMENT DATA FROM 2014 TO 2016
2. REVIEW OF THE 2016 ANNUAL REPORT INDICATES ALL PERSONAL IDENTIFIERS HAVE BEEN REMOVED FROM THE AGGREGATED DATA.
3. 2016 ANNUAL REPORT INCLUDE DISCLAIMER THAT PERSONAL IDENTIFIERS AND SPECIFIC LOCATIONS WHERE INCIDENTS OF SEXUAL ABUSE AND SEXUAL HARASSMENT OCCURRED HAVE BEEN REDACTED FROM THE REPORT AS INCLUSION WHOUL PRESENTA CLEAR AND SPECIFIC THREAT TO THE SAFETY AND SECURITY OF THE FACILITY, STAFF AND RESIDENTS.

IN CONCLUSION, AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.289

AUDITOR CERTIFICATION
I certify that:

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

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

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

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Auditor Signature & DATE