PREA AUDIT: AUDITOR'S SUMMARY REPORT
COMMUNITY CONFINEMENT FACILITIES

Name of facility: Cocaine and Alcohol Awareness Program			
Physical address: 3835 Lamar Avenue, Memphis, TN 38118			
Date report submitted: November 17, 2016			
Auditor Information: Melinda Allen			
Address: P.O. Box 703; Braselton, GA 30548			
Email: preaaudit@gmail.com			
Telephone number: 706-449-0003			
Date of facility visit: June 23-24, 2016			
Facility Information			
Facility mailing address: (if different from above) 4041 Knight Arnold Road, Memphis, TN 38118			
Telephone number:			
The facility is:	☐ Military ☐ Private for profit ☑ Private not for profit	☐ County ☐ Federal ☐ Municipal ☐ State	
Facility Type:	☐ Community Treatment Center ☐ Halfway House	☐ Alcohol or Drug Rehabilitation Center ☑ Community Based Confinement Facility	☐ Mental Health Facility ☐ Other:
Name of Facility Head: Mrs. Dorothy Bolden Nicks			
Email address: **dbolton@caapincoporated.com**			
Name of PREA Compliance Manager (if applicable):		**Title:**	
Email address:		**Telephone number:**	
Agency Information			
Name of agency: Cocaine and Alcohol Awareness Program			
Governing authority or parent agency: (if applicable) **N/A**			
Physical address: 4041 Knight Arnold Road, Memphis, TN 38118			
Mailing address: (if different from above)			
Telephone number: (901) 360-0442			
Agency Chief Executive Officer			
Name: Mr. Albert Richardson		**Title:**	Executive Director
Email Address: arichardson@caapincorporated .com		**Telephone Number:**	901-360-0442
Agency Wide PREA Coordinator			
Name: Mrs. Alisa F. Hayes		**Title:**	Alcohol and Drug Counselor
Email Address: ahayes@caapincoporated .com		**Telephone Number:**	(901) 794-0915

AUDIT FINDINGS

NARRATIVE:

Cocaine and Alcohol Awareness Program (CAAP) is a nonprofit substance abuse treatment agency located in Memphis, Tennessee. The facility is accredited by CARF, the Commission on Accreditation of Rehabilitation Facilities, a nationally recognized standard of excellence. The PREA Audit of the CAAP was conducted from June 23-24, 2016. The auditor wishes to extend its appreciation to Director Dorothy Bolden and her staff for the professionalism they demonstrated throughout the audit and for the kindness and hospitality they showed the auditor.

Following the Entrance Meeting, the auditor met with Director Bolden, Ms. Hayes, the PREA Coordinator and Ms. Crawford, the Compliance Manager. The auditor was given a through tour of the facility. After the tour, the auditor began the interviews of staff. The auditor also reviewed Human Resource files and staff training files at CAAP Headquarters located at 4041 Knight Arnold Road, Memphis, TN 38118.

There are currently 20 residents in the facility. Ten randomly selected residents were interviewed. Those interviewed were selected from a list of residents in the facility. In addition, residents who were identified as being in a designated group (i.e., disabled, limited English speaking ability, gay, or who had reported a sexual abuse, etc.) were also interviewed. In addition to interviewing residents, fourteen staff interviews were conducted. While the facility only employs 10 staff members at this facility, several of the staff members wear multiple hats and were interviewed on multiple protocols. Three staff members were randomly selected. Specialized staff member interviews included the Agency Head, Director, PREA Coordinator, Administrative Human Resources Staff and Staff Designated for Monitoring Retaliation.

When the on-site audit was completed, the auditor conducted an exit meeting with Director Bolden and PREA Coordinator Hayes. The auditor and staff agreed that there would be a need for corrective action and the auditor would provide the facility with a thorough interim report and a Corrective Action Plan within 30 days of the audit. The auditor provided an overview of the audit and thanked Director Bolden and PREA Coordinator Hayes for their hard work and dedication in working toward sexual safety and compliance with the PREA Standards.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The Cocaine and Alcohol Awareness Program is located in Memphis, Tennessee in Shelby County. The facility houses female residents only. The facility provides dining, recreation, and a multitude of programs geared toward substance abuse and addiction. The facility accommodates residents that were recently released from custody of the Tennessee Department of Corrections or that have violated their felony probation.

At the time of the audit, the facility held fifteen residents. There is one building that houses the residents. The facility has two open bay dormitories.

The on site audit was completed June 23-24, 2016. The interim report was provided June 28, 2016, to the CAAP reporting nineteen standards met compliance, eighteen standards do not meet and two standards are non-applicable. The final report was completed on November 17, 2016.

SUMMARY OF AUDIT FINDINGS:

Number of standards exceeded	00
Number of standards met	37
Number of standards not met	00
Number of standards non-applicable	02

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)

§115.211(a) – Meets Standard

§115.211(a) An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.211

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The Agency Head Designee, Director, PREA Coordinator, and a staff member in charge of monitoring retaliation.

In order to make a determination of compliance, the following observations were made during my on-site review of the facility: During the facility review, the auditor observed Resident Program Manuals and PREA signage displayed throughout the facility.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The Agency Head Designee, the PREA Coordinator, and a staff member in charge of monitoring retaliation were interviewed. Staff interviewed acknowledged the agencies zero tolerance policy, articulated the agencies protocols and explained on-going efforts to address this standard. Several staff members and residents were interviewed. All acknowledged the agencies zero tolerance culture and on-site information (signage). The resident manual includes definitions of inappropriate behaviors as well as sanctions for the behaviors. The auditor observed resident manuals as well as telephone numbers and information pertinent to reporting PREA incidents. The written policy outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. Residents are provided with PREA information at intake/orientation, which is taught by the PREA Coordinator. The training curriculum includes a PowerPoint and an opportunity for discussion.

Residents receive an Resident Handbook that includes information on reporting a PREA incident. The agency head designee, PREA Compliance Manager, investigative staff, line staff and residents all reported in interviews that sexual harassment and sexual abuse is against the facility rules and can lead to legal prosecution and/or other sanctions.

§115.211(b) – Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.211

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Program Director

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: the facility employs a Alcohol and Drug Counselor that serves as the PREA Coordinator.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in the facility it operates. The facility has created a written policy stating how they will implement the PREA standards, including strategies for reducing and preventing sexual abuse and harassment to residents. When interviewed, the PREA Coordinator stated that she has sufficient time and authority to oversee the efforts to comply with PREA.

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)

☒ Non-Applicable

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

This provision is non-applicable, as the facility does not contract with any facilities for the confinement of their residents.

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

This provision is non-applicable, as the facility does not contract with any facilities for the confinement of their residents.

§115.212(c) Only in emergency circumstances in which all reasonable attempts to find a private agency or other entity in compliance with the PREA standards have failed, may the agency enter into a contract with an entity that fails to comply with these standards. In such a case, the public agency shall document its unsuccessful attempts to find an entity in compliance with the standards.

This provision is non-applicable, as the facility does not contract with any facilities for the confinement of their residents.

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)

§115.213 (a)- Meets Standard

§115.213 (a) For each facility, the agency shall develop and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, agencies shall take into consideration: (1) The physical layout of each facility, (2) The composition of the resident population, (3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse, and (4) Any other relevant factors.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.213.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, and Program Director. The auditor found them knowledgeable of the dynamics of sexual abuse in confinement.

In order to make a determination of compliance, the following observations were made during my on-site review of the facility: The auditor conducted a thorough on-site review of the facility which included the physical layout of the facility, the video camera placement and the monitoring stations in the facility.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor conducted a thorough on-site review of the facility which included the physical layout of the facility, the video camera placement and the monitoring stations in the facility. The auditor reviewed the staffing plan. While the staffing plan addresses the basic staffing needs (numbers), the plan did not address the four enumerated factors in the standard:

(1) The physical layout of each facility;
(2) The composition of the resident population;
(3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(4) Any other relevant factors

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by creating and implementing a staffing analysis process that will include all significant parties such as facility administration, investigative staff, the PREA Coordinator and Human Resources Administrator. This should include an approach to discuss and fully answer each of the 4 points outlined in this provision. This corrective action shall be completed no later than September 24, 2016. There are resources available through the PREA Resource Center for Developing and Implementing a PREA Compliant staffing plan. This document can be found at: http://www.prearesourcecenter.org/sites/default/files/library/staffingplanfinalwbjalogosubmt.pdf

Update:

The staffing plan was revised to incorporate the factors required in the standards.

§115.213(b) – Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.213.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Facility Director.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Adequate numbers of staff were present during the on-site audit.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency has not had any staffing plans that were not complied with to date. The facility has "Per Diem" or PRN staff members that they can call in the event they are short staffed. If a PRN is not available, the Program Director will fill the slot.

§115.213(c) –Meets Standard

§115.213(c) Whenever necessary, but no less frequently than once each year, the facility shall assess, determine, and document whether adjustments are needed to: (1) The staffing plan established pursuant to paragraph (a) of this section; (2) Prevailing staffing patterns; (3) The facility's deployment of video monitoring systems and other monitoring technologies; and (4) The resources the facility has available to commit to ensure adequate staffing levels.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.213.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The auditor interviewed the Program Director, and the PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site review of the facility: The auditor observed a total of nineteen cameras inside the facility. The cameras outside the facility are to monitor the entry and egress of the facility. The auditor observed several blind spots in the facility to include in the kitchen. Video cameras are installed in the administrative areas, entry/hallways, common living room or dayroom, dining rooms, and multiple on the exterior of building, front, sides and rear. Video monitoring is designed as an adjunct to the direct observation and supervision of the residents and facility by on duty staff members. The video cameras may be viewed live or recorded. The recording is saved for 7 days.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency has developed and documented a staffing plan that provides adequate staffing and supervision to protect residents against sexual abuse. The facility does have several blind spots that are should be addressed in the facility kitchen and in the backyard. The facility should develop a three-year budgetary plan for improving the video monitoring. The agency has taken the physical layout, composition of the resident population, prevalence of substantiated and unsubstantiated incidents of sexual abuse and other relevant factors into consideration in developing the staffing plan. The staffing plan is reviewed annually.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by developing a three-year budgetary plan for improving the video monitoring and or the addition of convex mirrors in order to supplement the visuals in the kitchen and in the backyard areas.

Update: The facility has addressed the blind spots observed during the on site review by installing convex mirrors and repositioning cameras to improve video coverage of vulnerable areas.

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)

§115.215(a)- Meets Standard

§115.215(a) The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.215. The agency does not conduct any type of searches and they do not have any male staff members.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Director.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The agency does not conduct any type of searches and they do not have any male staff members.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency does not conduct any type of searches and they do not have any male staff members.

§115.215 (b)- Meets Standard

§115.215 (b) As of August 20, 2015, or August 20, 2017 for a facility whose rated capacity does not exceed 50 residents, the facility shall not permit cross-gender pat-down searches of female residents, absent exigent circumstances. Facilities shall not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.215.

In order to make a determination of compliance, the following people were interviewed and the following

interview findings were considered: The auditor interviewed a random selection of residents and a random Selection of staff members and determine that since this is an all female facility, females are never restricted from participating in regularly available programs.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: none.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does not conduct any pat searches of any kind. They are a female only facility. There are no male staff members at the facility.

§115.215(c)- Meets Standard

§115.215(c) The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches, and shall document all cross-gender pat-down searches of female residents.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.215.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random selection of staff and a random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: the facility does not conduct pat searches on any residents.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: the facility does not conduct pat searches on any residents.

§115.215(d)- Meets Standard

§115.215(d) The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.215.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of residents and random sample of staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The auditor observed the staff entering and exiting common areas and living quarters of the facility. All toilet areas are private and private showers are available for everyone to use.

The following describes how the evidence above was used to draw the final conclusion regarding compliance:

The agency has a policies and procedures that enable residents to shower, toilet and dress in a private area. The facility does not employ any male staff members.

§115.215(e)- Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.215, which prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining their genital status.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random selection of staff and a transgender resident.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Facility staff do not conduct any searches in the facility.

The following describes how the evidence above was used to draw the final conclusion regarding compliance:

The auditor interviewed a random selection of Staff and determined that Transgender or Intersex residence would not be searched or physically examined for the sole purpose of determining their genital status. The auditor interviewed a transgender resident and determined that he was not strip searched to determine his genital status.

§115.215 (f)- Meets standard

§115.215 (f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.215.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: CAAP does not pat search any residents. The facility does use a wand to assist with detecting contraband.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Staff do not conduct pat searches of any kind in the facility.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Staff members do not conduct pat searches in the facility.

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)

§ 115.216(a)- Meets Standard

§ 115.216(a) The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.216

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head, PREA Coordinator and a random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Signage in the facility as well as resident manuals.

The following describes how the evidence above was used to draw the final conclusion regarding compliance:

The agency has not taken steps to ensure that residents with disabilities have an equal opportunity to participate in all aspects of the agency's efforts to prevent, detect and respond to any sexual abuse or sexual harassment. The facility has not does ensured effective communication, for residents who are blind or have low vision. The facility has not indicated how it would accommodate residents that have disabilities, or have limited intellectual disabilities, and limited reading skills. The Program Manual, which was provided to this auditor is a handbook written for the State of Washington and provided contact information in Washington. The handbook, if it is going to be used, should be personalized for CAAP.

Update: CAAP has initiated the process of providing a bilingual staff member to assist with

interpretation. They have also reached out to several community programs to provide assistance with communicating with deaf and/or disabled clients. Staff members use pictures, videos, audio, and one on one sessions with residents that are intellectually challenged.

§ 115.216(b)- Meets standard

§ 115.216(b) The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Sexual Misconduct Policy, Program Manual, and Contract with Interpreter/Other Requested/Documentation.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered:

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The auditor was unable to locate any residents with disabilities or non-English proficiency.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor was unable to locate any residents with disabilities or non-English proficiency. This determination was based solely on policy and observations during the review of the facility. The facility has not contracted with an interpretation service to provide for foreign language interpretation. They have hired a bilingual staff member that speaks Spanish.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by establishing a protocol for using a translation line as needed for non-English speaking residents. Many of these services are available as a pay as you go service to be used only as needed.

Update: CAAP has initiated the process of providing a bilingual staff member to assist with interpretation. They have also reached out to several community programs to provide assistance with communicating with deaf and/or disabled clients. Staff members use pictures, videos, audio, and one on one sessions with residents that are intellectually challenged. The facility has also created a resident handbook in Spanish that is available for Spanish speaking clients.

§ 115.216(c)- Meets standard

§ 115.216(c) The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.216.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of staff. The auditor was unable to locate any residents with disabilities or non-English proficiency.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor reviewed Policy 115.216 and interviewed a random selection of staff who indicated that interpreters would be provided for residents or the information made available in foreign languages. A resident reader or resident interpreter may be used in limited situations, but never for a PREA incident. The auditor was unable to locate any Residents with disabilities or non-English proficiency to interview.

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)

§ 115.217 (a)- Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.217.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Program Manager, HR Administrative Staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Visually reviewed documentation of records checks and interviews for employees. Secured copies that indicated checks were completed.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents if they have engaged in sexual abuse, accused or adjudicated guilty of attempting to abuse persons in confinement. This auditor reviewed records that indicate that the agency does background checks both in Tennessee and nationally. The agency has hired another company to complete the background checks. While the

agency has documentation proof of the completion of a criminal background check and a review of the sex offender registry, there is no indication that the agency checks to determine if the potential employee/promotion has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by establishing a protocol reviewing civil and administrative records to determine if the individual has been adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. This should be documented in the personnel file.

Update:
CAAP has modified their hiring process to incorporate reviewing civil and administrative records to determine if the individual has been adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. They also created a form to use to document the review.

§ 115.217(b)- Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.217, personnel files, files of contractors and volunteers. There was no indication that there had been any recent promotions at CAAP.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Administrative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: CAAP completes a thorough criminal background investigation, but records do not reflect an attempt regarding incidents of sexual harassment prior to hiring, promoting or enlisting services of contractors who may have contact with the residents.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAP completes a thorough criminal background investigation, but records do not reflect an attempt regarding incidents of sexual harassment prior to hiring, promoting or enlisting services of contractors who may have contact with the residents. The auditor reviewed the log of background checks for staff, contractors and volunteers.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by establishing a protocol to document checks for incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

Update: CAAP has modified their hiring process to incorporate reviewing civil and administrative records to determine if the individual has been adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. They also created a form to use to document the review.

§ 115.217 (c)- Meets Standard

§ 115.217 (c) Before hiring new employees who may have contact with residents, the agency shall:
(1) Perform a criminal background records check; and
(2) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.217, personnel files.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Administrative Staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The auditor reviewed the logs for background checks while at the CAAPs administrative offices.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor interviewed the on site Administrative Human Resource Staff member who indicated that a criminal history and a sex offender check is completed for new hires, contractors and volunteers. The auditor was able to review documentation in the form of a log that indicated staff members had the necessary criminal record reviewed prior to hiring. The auditor was unable to locate any documentation that the agency contacted all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by establishing a protocol to document checks for contacting all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

Update: CAAPs had modified their policy and hiring practices to include preforming a criminal background check and making best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

§115.217 (d)- Meets standard

§115.217 (d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with residents.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.217, contractor files.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Administrative staff.

In order to make a determination of compliance, the following observations were made during my on-site

tour of the facility: Review of applications for contractors and log of background checks for contractors, staff and volunteers.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAP completes a thorough criminal background investigation before enlisting services of contractors who may have contact with the residents. The auditor reviewed the log of background checks for staff, contractors and volunteers.

§ 115.217 (e)- Meets Standard

§ 115.217 (e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees.
In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.217, personnel and contractor files.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Administrative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of personnel files for confirmation of completion of criminal history background checks.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility conducts criminal background checks when hiring or contracting but do not complete a criminal background check every five years thereafter.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by establishing a protocol to complete background checks for all personnel and contractors who may have contact with residents every five years.

Update: The agency has established a protocol for completing background checks of all personnel and contractors who may have contact with residents. The agency completed a background check on each employee/contractor that had not been checked in the pervious five years and established a process for ensuring that the appropriate background checks are completed moving forward.

§115.217(f)- Meets Standard

§115.217(f) The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.217, personnel files.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Administrative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of staff personnel documents.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency has a policy that mandates applicants and employees, who have contact with residents, are asked about conduct described in paragraph (a) of 115.217. The facility also imposes a continuing affirmative duty to disclose any such misconduct. The auditor was unable to locate any proof in written applications or documentation of interviews that applicants/employees are asked directly about previous misconduct described in paragraph (a) of this section.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by establishing a protocol to inquire about the three questions listed below during the interview/hiring process:

> (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. § 1997);
> (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
> (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

Update: CAAPs has revised their hiring policies and procedures to include asking all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

§115.217(g)- Meets standard

§115.217(g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.
In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.217, personnel files.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Administrative Staff, Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor reviewed the Policy for compliance with this standard. The policy, in section g states, "Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination."

§115.217 (h)- Meets standard

§115.217 (h) Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.217.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Administrative Staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: administrative staff at the CAAP handles all requests or inquiries regarding former employees. Staff indicated that the only information provided is the dates of employment. Staff could not provide me with any local laws that prevent them from providing information on substantiated allegations of sexual abuse or sexual harassment.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by establishing a protocol to provide the 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 unless there is a law that forbids disseminating the information. If there is a law, the agency shall notify the auditor of the State Statute.

Update: The agency has established a policy that requires their human resources to provide the necessary information to an institutional employer for whom the employee has applied to work, unless there is a law that forbids dissemination of the information.

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)

§115.218(a)- Non-Applicable

§115.218(a) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the residents from sexual abuse. (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012 or since the last PREA audit, whichever is later.)

In order to make a determination of compliance, the following policies and other documentation were reviewed: None.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager, Agency Head.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The agency has not acquired or made a substantial expansion to the existing facility since August 20, 2012.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency has not acquired or made a substantial expansion to the existing facility since August 20, 2012.

§115.218(b)- Non-Applicable

§115.218(b) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may residents from sexual abuse. (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)

In order to make a determination of compliance, the following policies and other documentation were reviewed: None.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head, Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The facility has not upgraded the video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. The facility has 19 cameras in the facility. There are a several blind spots in the facility kitchen where the facility could add mirrors to assist with viewing blind spots as well as in the back yard to improve visibility behind the large dumpsters. The agency should develop a three-year budget plan for addressing the blind spots and vulnerable areas noted.

Recommendation: The agency should develop a three-year budget plan for addressing the blind spots and vulnerable areas noted.

Update: CAAPs has made several modifications to the monitoring system to allow for improved coverage of the facility and yard areas.

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)

§115.221(a)- Non-Applicable

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.221.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Random sample of staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The facility does not complete sexual abuse investigations. They rely on the Memphis Police Department to conduct all criminal investigations. The PREA Coordinator indicated that she would conduct an administrative investigation (non-criminal) and that the Memphis Police Department would be called to conduct any criminal investigations. The facility has developed a response Plan, including Staff First Responder, Supervisory, and PREA Coordinator Responsibilities.

§115.221 (b)- Non-Applicable

§115.221 (b) The protocol shall be developmentally appropriate for youth where applicable, and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.221.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does not conduct sexual abuse investigations. These investigations are referred to the Memphis Police Department for investigation and prosecution.

§115.221(c)- Meets Standard

§115.221(c) The agency shall offer all victims of sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.221.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Local SAFE/SANE Staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility offers to all residents who experience sexual abuse access to forensic medical examinations. The agency has developed a policy that a SAFE/SANE should be utilized in the investigation of a sexual abuse incident. Forensic medical examinations are offered without financial cost to the victim. When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. In the past 12 months, no forensic examinations were conducted on behalf of the facility. The auditor interviewed local SAFE/SANE staff that would provide services for the CAAP.

§115.221 (d)- Meets standard

§115.221 (d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.221 and the MOU with the Family Safety Center.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator. The auditor was unable to locate any residents that had reported a sexual abuse.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAP has an Memorandum of Understanding signed with the Family Safety Center that the Family Safety Center will provide confidential victim support and crisis intervention services, including as appropriate, a qualified victim advocate. As requested by the victim, the victim advocate may accompany and support the victim through the forensic medical examination process and investigatory interviews and provide emotional support, crisis intervention, and other information and/or referrals. The MOU was signed on March 11, 2016.

§115.221 (e) Meets Standard

§115.221 (e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.221.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator. The auditor was unable to locate any residents that had reported a sexual abuse.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The Phoenix House has an Memorandum of Understanding signed with the Family Safety Center to provide confidential victim support and crisis intervention services, including as appropriate, a qualified victim advocate. As requested by the victim, the victim advocate may accompany and support the victim through the forensic medical examination process and investigatory interviews and provide emotional support, crisis intervention, and other information and/or referrals. The MOU was signed on March 11, 2016.

§115.221 (f)- Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.221.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency is not responsible for investigating allegations of sexual abuse. The agency would contact the Memphis Police Department for investigation. The agency/facility has contacted these agencies to ensure they are following the requirements set forth in (a) through (e) of this standard. The facility has a verbal agreement that the investigative agency will follow the necessary requirements of this standard.

§115.221 (g)- Non applicable

§115.221 (g) The requirements of paragraphs (a) through (f) of this section shall also apply to:
(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in community confinement facilities; and
(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in community confinement facilities.

§115.221 (h)- Non-applicable

§115.221 (h) For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

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)

§115.222 (a) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.222.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head, Program Manager, PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency has a policy that an investigation (administrative or criminal) will be conducted for each complaint made in the facility.

§115.222(b) Meets Standard

§115.222(b) The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its Web site or, if it does not have one, make the policy available through other means. The agency shall document all such referrals.

In order to make a determination of compliance, the following policies and other documentation were reviewed: CAAP Website, Policy 115.222.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative Staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. However, the agency does not currently publish such policy on its Web site or make the policy available through other means. The agency does document all referrals.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished.. The facility shall publish such policy on its Website.

Update: CAAPs had added information to their website at http://www.caapincorporated.com/community-corrections-service/ which provides the agency policy on investigations as well as referrals.

§115.222(c) Meets Standard

§115.222(c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.222.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The policy does not address the responsibilities of the investigating entity.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished.. The facility shall publish the responsibilities of the investigating entity. The policy should be revised to include: who is responsible for conducting criminal investigations, such **publication** shall describe the responsibilities of both the agency and the investigating entity.

Update: CAAPs has clearly indicated that the PREA SART team will initiate and complete an in-house investigation of all allegations of sexual abuse and sexual harassment. If the investigation is suspected to be of a criminal nature the team will refer the incident promptly, thoroughly and objectively to the MEMPHIS POLICE DEPARTMENT to determine if a criminal investigation is warranted.

§115.222 (d) Non-Applicable

§115.222 (d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations.

§115.222 (e) Non-Applicable

§115.222 (e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations.

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)

§ 115.231 Employee training- Meets standard

§ 115.231 Employee training.

(a) The agency shall train all employees who may have contact with residents on:

(1) Its zero-tolerance policy for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;

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

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

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

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

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

(8) How to avoid inappropriate relationships with residents;

(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and
(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.231. review of training curriculum, documentation of completion of training.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has provided training for the staff. However, the curriculum used is not

consistent with standard requirements. The curriculum was clearly adopted from a prison or jail facility; and did not include #3, 4,5,6,7,8,9,or 10.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished.. The training curriculum shall be revised to encompass all of the required topics. Once the curriculum has been revised, staff should be retrained and the training documented.

Update: Additional training documents were provided that included the required criteria for training.

§ 115.231 (b) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.231.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random Sample of Staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Sample of staff training records.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor reviewed the training curriculum provided to the staff at CAAP. The curriculum presented does not meet the standards required. The auditor reviewed a sampling of staff training records to confirm completion, in addition to conducting interviews with staff to verify understanding.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished.. The training curriculum shall be tailored to the gender of the residents, female.

Update: The training was revised to be tailored for female residents.

§115.231(C) Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.231.

In order to make a determination of compliance, the following people were interviewed and the following

interview findings were considered: Program Manager, PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of staff training records.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor reviewed a sample of staff training records to confirm completion, in addition to conducting interviews with staff to verify understanding. Staff completed the training in September 2015. The facility will provide the refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

§115.231 (d) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115,231, review of employee training records.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager, PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of staff training records.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor reviewed the training records of a sampling of staff at CAAP to confirm completion, in addition to conducting interviews with staff to verify understanding. All staff completed the training in September 2015.

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)

§115.232(a) Meets standard

§115.232(a) The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.232.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Contractor.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of training confirmation.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has very few contractors or volunteers that enter the facility and have contact with residents. The auditor was able to interview one contractor at the facility who indicated that she received PREA training and the auditor verified the completion of the training.

§115.232(b) Meets Standard

§115.232(b) The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.232.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Contractor.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of training confirmation.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has very few contractors or volunteers that enter the facility and have contact with residents. The auditor was able to interview one contractor at the facility who indicated that she received PREA training and the auditor confirmed the completion of the training.

§115.232(c) Meets standard

§115.232(c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.232.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Contractor.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of training confirmation.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has very few contractors or volunteers that enter the facility and have contact with residents. The auditor was able to interview one contractor at the facility who indicated that she

received PREA training and the auditor confirmed the completion of the training.

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)

§115.233(a) Meets standard

§115.233(a) During the intake process, residents shall receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.233.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Intake Staff, random sample of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. No new residents were brought into the facility during the on site audit.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility typically provides resident training within 72 hours of arrival. I was unable to confirm that residents are provided basic information regarding the zero-tolerance policy and how to report and incident during the intake process. This information is provided during the orientation process that takes place approximately 72 hours after arrival at the facility.

Informs new residents of the zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents during the initial intake process. Interviews with a random selection of residents and the intake staff member confirm compliance with this provision.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. The residents shall be provided basic information regarding the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents during the intake process, immediately upon entry into the facility.

Update: CAAP has added information to the resident handbook, given to all clients, that provides basic information regarding the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, how

to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents

§115.233(b) Non-Applicable

§115.233(b) The agency shall provide refresher information whenever a resident is transferred to a different facility.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.233.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Intake staff and a random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility informs new residents of the zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents during Orientation within 10 days. However, the facility does not transfer resident to different facilities from the CAAP.

§115.233(c) Meets standard

§115.233(c) The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.233.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Intake staff and a random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Visually observed the training curriculum for residents. The training is only presented in English. The auditor did not observe any accommodations for deaf or non-English proficient residents.. Staff members read and explain the information to the residents as needed in the event they have difficulty reading, or limited cognitive skills.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Visually observed the training curriculum for residents. The training is only presented in English. The auditor did not observe any accommodations for deaf or non-English proficient residents.. Staff members read and explain the information to the residents as needed in the event they have difficulty reading, or limited cognitive skills.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. The resident training

curriculum should be provided in a variety of formats to accommodate a variety of residents to include those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills.

Update: CAAP has provided information in a variety of formats to accommodate a variety of residents to include those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills.

§115.233(d)- Meets standard

§115.233(d) The agency shall maintain documentation of resident participation in these education sessions.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.233.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Intake staff and random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Sample of documentation verifying resident participation and understanding of the PREA training.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor interviewed a random selection of residents and the intake staff. Each individual confirmed that the residents are required to sign that they participated in the required PREA training.

§115.233(e) Meets standard

§115.233(e) In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.233, observation of PREA Posters and signage.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Education and informational materials are available throughout the facility.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor observed materials on site that were readily available to residents at all times.

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)

§115.234 (a) Meets Standard

§115.234 (a) In addition to the general training provided to all employees pursuant to ¨115.231, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.

(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.234.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Training Records and logs of training completed.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAP has not provided training for its investigators. All investigators must complete specialized training in conducting sexual abuse investigations in confinement settings, including training on techniques for interviewing sexual abuse victims and the evidence required to substantiate the case. The NIC has developed training curriculum for sexual abuse investigations in confinement settings that can be located: http://www.prearesourcecenter.org/node/1912 ; In addition, the training on techniques for interviewing sexual abuse victims and the evidence required to substantiate the case are taught by most POST (Peace Officer Standards and Training) facilities.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. All investigators shall be trained in conducting sexual abuse investigations in confinement settings, including training on techniques for interviewing sexual abuse victims and the evidence required to substantiate the case. Once the training has been completed, proof documentation of completion shall be provided.

Update: The agency has had two employees complete the required training in techniques for interviewing sexual abuse victims and the evidence required to substantiate the case. The facility will only be conducting administrative investigations. All criminal investigations will be forwarded to the local law enforcement authorities.

§115.234 Meets standard

§115.234 Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.234 indicated that CAAP does not conduct any form of criminal or administrative sexual abuse investigations.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff, PREA Coordinator, and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Training records.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: No curriculum was provided to review for the specialized training of investigative staff. While the policy states that CAAP does not conduct any form of criminal or administrative sexual abuse investigations, interviews with staff indicate that they would conduct Administrative investigations should the need arise. All criminal investigations are referred to the Memphis Police Department for investigation and consideration of prosecution.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. All investigators shall be trained in conducting sexual abuse investigations in confinement settings, including training on techniques for interviewing sexual abuse victims and the evidence required to substantiate the case. Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Once the training has been completed, proof documentation of completion shall be provided.

Update: The agency has had two employees complete the required training in techniques for interviewing sexual abuse victims and the evidence required to substantiate the case. All investigators were trained in conducting sexual abuse investigations in confinement settings, including training on techniques for interviewing sexual abuse victims and the evidence required to substantiate the case. Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The facility will only be conducting administrative investigations. All criminal investigations will be forwarded to the local law enforcement authorities.

§115.234 (c) Meets Standard

§115.234 (c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.234, review of staff training records.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative Staff, PREA Coordinator and Program Manager..

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAP has not provided training for its investigators.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. All investigators shall be trained in conducting sexual abuse investigations in confinement settings, including training on techniques for interviewing sexual abuse victims and the evidence required to substantiate the case. Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Once the training has been completed, proof documentation of completion shall be provided.

Update: Two staff members were trained in techniques for interviewing for administrative investigations. All criminal investigations will be conducted by local law enforcement. Documentation of completion of training was provided to the auditor.

§115.234 (d) Non-applicable

§115.234 (d) Any State entity or Department of Justice component that investigates sexual abuse in confinement settings shall provide such training to its agents and investigators who conduct such investigations.

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)
- ☒ Non-Applicable

§115.235(a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:

(1) How to detect and assess signs of sexual abuse and sexual harassment;
(2) How to preserve physical evidence of sexual abuse;
(3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and
(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

CAAP does not employ any Medical or Mental Health Staff.

§ 115.235(b) Non-applicable

§ 115.235(b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.

§ 115.235(c) Non-Applicable

§ 115.235(c) The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

CAAP does not employ any Medical or Mental Health Staff.

§115.235(d) Non-Applicable

§115.235(d) Medical and mental health care practitioners shall also receive the training mandated for employees under §115.231 or for contractors and volunteers under §115.232, depending upon the agency.

CAAP does not employ any Medical or Mental Health Staff.

Standard	§115.241 Screening for 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)

§115.241 (a) Meets standard

§115.241 (a) All residents shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.241 and Risk Screening assessment instrument.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Intake staff, staff responsible for risk screening and a random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The auditor observed a random sample of risk assessment instruments that had been completed on residents.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor reviewed the risk-screening instrument and verified the use of the instrument for each resident. The instrument assesses the risk of being sexually abused by other residents or sexually abusive toward other residents.

§115.241 (b) Meets standard

§115.241 (b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.241 and a sampling of completed risk screening assessments.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of residents and staff responsible for risk screening.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Screening instruments for residents housed at the facility.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has developed a risk-assessment instrument that they complete for each resident. The assessments are normally completed at intake, or within 72 hours of admission. The auditor reviewed a random selection of risk-screening assessment tools to confirm that the assessments are completed in a timely manner.

§115.241(c) Does Not Meet Standard

§115.241(c) Such assessments shall be conducted using an objective-screening instrument.
In order to make a determination of compliance, the following policies and other documentation were

reviewed: Policy 115.241 and a review of the risk screening assessment instrument.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The auditor reviewed and secured a copy of the risk-screening instrument used at CAAP.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor secured a copy of the risk assessment tool being used by CAAP. The assessment tool is not an objective instrument used to determine one's risk of being sexually abused and of abusing others. The instrument currently being used is not 100% objective. In order to be objective, the instrument must not be influenced by personal feelings or opinions in considering and representing facts.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. Revise the screening instrument to be an objective instrument that assesses residents for risk of sexual victimization.

Update: The screening instrument was revised to objectively assess resident's risk of sexual victimization.

§115.241(d) Meets standard

§115.241(d) The intake screening shall consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:

(1) Whether the resident has a mental, physical, or developmental disability;
(2) The age of the resident;
(3) The physical build of the resident;
(4) Whether the resident has previously been incarcerated;
(5) Whether the resident's criminal history is exclusively nonviolent;
(6) Whether the resident has prior convictions for sex offenses against an adult or child;
(7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;

(8) Whether the resident has previously experienced sexual victimization; and
(9) The resident's own perception of vulnerability.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.241, Risk Screening Instrument.

In order to make a determination of compliance, the following people were interviewed and the following were interviewed: Staff responsible for risk assessment, random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of risk-assessment instrument.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has developed a risk assessment instrument. The instrument does not address each of the nine criteria required by this provision.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. Revise the screening instrument to be an objective instrument that assesses residents for risk of sexual victimization utilizing the nine criteria in 115.241(d).

(1) Whether the resident has a mental, physical, or developmental disability;
(2) The age of the resident;
(3) The physical build of the resident;
(4) Whether the resident has previously been incarcerated;
(5) Whether the resident's criminal history is exclusively nonviolent;
(6) Whether the resident has prior convictions for sex offenses against an adult or child;
(7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
(8) Whether the resident has previously experienced sexual victimization; and
(9) The resident's own perception of vulnerability.

Criteria elements 2, 5 &7 should to be added to the new assessment instrument.

Update: the Factors 2, 5, and 7 were added to the Screening Instrument.

§115.241(e) Meets Standard

§115.241(e) The intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.241, risk-screening instrument.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Staff responsible for risk assessment.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance:

The auditor reviewed the risk-screening instrument used at CAAP. The intake screening does consider prior acts of sexual abuse, prior convictions for violent offenses, and the history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive.

§115.241(f) Meets standard

§115.241(f) Within a set time period, not to exceed 30 days from the resident's arrival at the facility, the facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.241, reviewed risk-screening reassessments.

In order to make a determination of compliance, the following people were interviewed and the following were interviewed: Staff responsible for risk screening and a random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The auditor reviewed resident files for completion.

The following describes how the evidence above was used to draw the final conclusion regarding compliance:

The facility has implemented a 30-day reassessment of the resident's risk of victimization or abusiveness; the auditor reviewed a sampling of risk screening reassessment for compliance and determined that the reassessments are being completed.

§115.241(g) Meets standard

§115.241(g) A resident's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.241 and Risk Screening Reassessment Instrument.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Staff responsible for risk screening and a random selection of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that requires the resident's risk level to be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. The auditor was unable to review any documentation of this reassessment because the facility did not have a resident that met the qualifications at the time of the audit.

§115.241(h) Meets standard

§115.241(h) Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.241.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Staff responsible for risk screening.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states a resident will not be disciplined for refusing to answer or disclose information in response to questions in paragraphs (d)(1), (d)(7), (d)(8), or (d)(9). The policy states, "(h) Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(I), (d)(7), (d)(8), or (d)(9) of this section." The facility has developed a screening tool. Residents are not disciplined for refusing to answer these sensitive questions.

§115.241(i) Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.241.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator/Compliance Manager and staff responsible for risk screening.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Review of placement of the risk screening assessment instrument.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The completed risk screening assessment tools are stored in the resident's files which are secured in the PREA Coordinator's office. Access to the files is limited to those staff members that need to know the information contained in the assessments.

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)

§115.242 (a) Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.242.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and staff responsible for risk screening.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Staff that complete the risk screening assessment use information from the risk screening to determine housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.

§115.242 (b) Meets standard

§115.242 (b) The agency shall make individualized determinations about how to ensure the safety of each resident.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.242.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Staff responsible for risk screening.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Staff responsible for risk screening make individualized determinations about how to ensure the safety of each resident based on the responses in the screening instrument.

§115.242(c) Meets Standard

§115.242(c) In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.242.

In order to make a determination of compliance, the following people were interviewed: PREA Coordinator and a Transgender resident.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Observation of private shower and toilet areas.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The agency makes individualized plans as needed to ensure the safety of each resident, including specific attention to the placement of transgender or intersex residents. The auditor observed private shower and toilet areas that are made available to transgender and/or intersex residents. The auditor interviewed a transgender resident who indicate that he was allowed to shower and use the toilet in private.

§115.242(d) Meet standard

§115.242(d) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.242.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The PREA Coordinator, staff responsible for risk screening and a transgender resident were interviewed.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy gives serious consideration to each transgender or intersex resident's own views with respect to his or her own safety.

§115.242(e) Meets standard

§115.242(e) Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Sexual Misconduct Policy, Revised 10.18.2015.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The PREA Coordinator, staff responsible for risk screening and a transgender resident were interviewed.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy gives serious consideration to each transgender or intersex resident's own views with respect to his or her own safety and individual, private shower stalls are available for use by any resident. The resident interviewed indicated that he can get undressed and redress inside the shower room stall.

§115.242(f) Meets standard

§115.242(f) The agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.242.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The PREA Coordinator, staff responsible for risk screening and a transgender resident were interviewed.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The auditor did not observe any dedicated units or wings being used as dedicated housing units for lesbians, bisexual or intersex residents.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status. The facility is not subject to any consent decrees, legal settlements, or legal judgments for the purpose of protecting such residents.

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)

§ 115.251(a) Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.251, Resident Handbook.

In order to make a determination of compliance, the following people were interviewed and the following

interview findings were considered: Random sample of staff and residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: PREA Posters, PREA Hotline Phone, and Resident Handbooks.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Residents may email, speak to staff privately in person, or submit a grievance in order to report sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

§115.251(b) Meets standard

§115.251(b) The agency shall also inform residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.251.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and random sample of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Observation of contact information posted throughout the facility.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAP provides a mechanism for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. The residents may contact the Family Safety Center or the PREA Hotline by telephone 1-865-522-7273. The telephone calls are currently free as the pay phone is out of order. Residents may call anyone they please. It should be noted that the telephone dedicated for PREA phone calls is a single telephone and anyone that is observed on the phone would lose all confidentiality by their mere presence on the phone. However, residents may use other telephone to call the number from other phones.

§115.251(c) Meets standard

§115.251(c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.251.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of staff and residents.

In order to make a determination of compliance, the following observations were made during my on-site

tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Staff and residents interviewed all indicated that residents my file a report verbally, in writing, anonymously or through the use of a third party. Staff indicated that they would promptly document any verbal reports.

§115.251 (d) Meets standard

§115.251 (d) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.251.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Staff seem to have an excellent working rapport with the Facility Program Manager and PREA Coordinator. Staff interactions were open and well received.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Staff is able to privately report sexual abuse or sexual harassment of residents to facility leadership. The facility staff has an excellent working rapport with the Facility Program Director and PREA Coordinator.

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)

§115.252(a) Meets Standard

§115.252(a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.252, reviewed grievances 2014-2016.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Reviewed all grievances from 2014-current.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does have a formal grievance policy in place, therefore they are not exempt from this standard.

§115.252(b) Meets standard

§115.252(b)

(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
(2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.252, grievances and resident Program manual.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does not impose a time limit on grievances regarding sexual abuse. Residents are not required to use the informal grievance process to report sexual abuse. CAAP policy indicated that "CAAP Inc. is exempt from this policy." However, since they do have an administrative procedure to address resident grievances regarding sexual abuse, they are not exempt. Their policy does include the required timelines and processes but it always states that they are exempt from the policy.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. Revise this policy to indicate that CAAP is subject to this provision.

CAAP has revised policy 115.252, grievances and resident Program manual, to reflect that they are subject to this provision. Clients and staff were trained on the revised policy.

§115.252(c) Meets Standard

§115.252(c) The agency shall ensure that—

(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.252 and resident program manual.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Program Manager and a Random sample of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Residents may utilize the formal grievance procedure to report such incidents or information. However, residents are not required to go through the formal resolution steps to report an incident. However, the policy should be revised as the policy states that CAAP is exempt from this policy.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. Revise this policy to indicate that CAAP is subject to this provision.

CAAP has revised policy 115.252, grievances and resident Program manual, to reflect that they are subject to this provision. Clients and staff were trained on the revised policy.

§115.252(d)- Meets standard

§115.252(d)

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.252.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The auditor was unable to locate any residents that had reported a case of sexual abuse. The auditor did interview a random sample of residents and staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Facility policies regulate the deadlines and guidelines governing grievances and responses. Both staff and residents interviewed indicated that grievances are addressed expediently and without delay. The agency policy in place that follows the guidelines of this standard.

§115.252(e)- Meets standard

§115.252(e)

(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.
(2) If a third party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.
(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.252.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: If a third party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the grievance process. If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision. The policy is very clear regarding these requirements. The auditor was unable to locate any cases to review for verification or confirmation.

§115.252(f) Meets standard

§115.252(f)

(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.
(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.252.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor was able to review any emergency grievances related to sexual abuse or harassment in facility policy, but this information has not been relayed to residents. If residents are not familiar with this policy, they do not know that they can write an emergency grievance.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and the timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. Revise the Resident Handbook to include information about how to submit an emergency grievance. The information should include how to submit and the accompany timelines.

Update: CAAP has revised policy 115.252, grievances and resident Program manual, to reflect that they are subject to this provision. The facility incorporated the use of Emergency Grievances with the required elements. Clients and staff were trained on the revised policy.

§115.252(g) Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.252. The auditor was unable to locate any disciplinary reports for filing a grievance in bad faith.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The facility does have a policy in place that allows for disciplining a resident for filing a grievance in bad faith.

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)

§115.253(a) Meets Standard

§115.253(a) The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.253, the PREA Brochure and the Resident Handbook.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and a random sample of residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The facility has posted this information throughout the facility. Residents interviewed were very familiar with the resources that are available.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has provided residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations, in as confidential a manner as possible. The PREA Brochure that contains this information indicates that the Sheriff's Office has a zero-tolerance policy.

Update: The PREA Brochure was revised to read that the CAAP has a zero-tolerance policy.

§115.253 (b) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.253 and Training Curriculum.

In order to make a determination of compliance, the following people were interviewed: Random Sample of Residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Residents are advised that all telephone calls or communications to report abuse would be confidential. Telephone calls are not screened at CAAP. Residents interviewed are familiar that their calls are confidential.

§115.253 (c) Meets Standard

§115.253 (c) The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.253 and MOU with the Family Safety Center.

In order to make a determination of compliance, the following people were interviewed: PREA Coordinator and a Random Sample of Residents.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has entered into a MOU with the Family Safety Center, signed on March 11, 2016 to provide for confidential emotional support related to sexual abuse.

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)

§115.254 Meets standard

§115.254 The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.254.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The auditor did not observe any evidence of a method of reporting third-party reports of sexual abuse and sexual harassment. The information is not publicly distributed.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Policy 115.254 indicated that this information would be available on the website. The auditor did not observe any information regarding method of reporting third-party reports of sexual abuse and sexual harassment.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. The facility shall publish the method for third party reporting so it is readily available to the public.

Update: CAAP has published the following: Any third party reports of sexual abuse may be made via telephone: 901-794-0915 fax: 901-566-9242 email: caapincorporated @bellsouth.com or in person. The facility email address, telephone and facsimile numbers are available publicly on CAAP, INC website.

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)

§115.261(a)- Meet standard

§115.261(a) The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.261.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to immediately report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment in the facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff interviewed all indicate that there is an affirmative responsibility to report any incident or suspicion of sexual abuse or sexual harassment.

§115.261(b) Meet standard

§115.261(b) Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.261.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Random sample of staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy states, “Apart from reporting to designated officials, staff will not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions;” Staff interviewed confirm that information is not disseminated, except on a need to know basis.

§115.261(c) Meets standard

§115.261(c) Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.261. There were no reports to review of medical or mental health reporting sexual abuse.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Interviews with mental health staff indicate that staff do have a duty to report and they do disclose to the residents this duty to report and the limitations of confidentiality at the initiation of services.

§115.261(d) Meets the standard

§115.261(d) If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.261.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Mental Health Staff

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Facility policy states, “Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners are required to report sexual abuse and to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services; if the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency must report the allegation to the designated State or local services agency

under applicable mandatory reporting laws." Mental Health staff interviews confirm compliance with this provision.

§115.261(e) Meets standard

§115.261(e) The facility shall report all allegations of sexual abuse and sexual harassment, including third party and anonymous reports to the facility's designated investigators.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.261.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. There were no sample investigative reports to review. The auditor did not find any reports presented by a third-party or any anonymous reports.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to report all allegations of sexual abuse and sexual harassment, to include third-party and anonymous reports to the facility's designated investigators.

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)

§115.262(a) Meets standard.

§115.262(a) When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.262.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head, Program Director and random sample of staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Facility policy requires staff to take immediate action to protect the resident when they learn that a resident is subject to a substantial risk of imminent sexual abuse. Staff interviewed all confirmed this requirement.

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)

§115.263(a) Meets Standard

§115.263(a) Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.263.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: There were no reports to review; however, the facility does have a policy that addresses notifying the head of the facility if an allegation has been made that a resident was abused while in another facility and staff leadership is familiar with the policy.

§115.263(b) Meets standard

§115.263(b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.263.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Facility Director.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: There were no reports to review; however, the facility does have a policy that addresses notifying the head of the facility if an allegation has been made that a resident was abused while in another facility and staff leadership is familiar with the policy.

§115.263(c) Meets standard

§115.263(c) The agency shall document that it has provided such notification.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.263.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: There were no reports to review; however, the facility does have a policy that addresses notifying the head of the facility if an allegation has been made that a resident was abused while in another facility and staff leadership is familiar with the policy.

§115.263(d) Meets standard

§115.263(d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.263.

In order to make a determination of compliance, the following people were interviewed: The Program Manager and Agency Head were interviewed.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: There were no reports to review; however, the facility does have a policy that addresses notifying the head of the facility if an allegation has been made that a resident was abused while in another facility and staff leadership is familiar with the policy.

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)

§115.264 (a) Meets Standard

§115.264 (a) Upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

(1) Separate the alleged victim and abuser;

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

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

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.264, Training Curriculum for Staff.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Security staff and non-security staff first responders. The auditor was unable to locate any residents that had reported a sexual abuse case in the facility.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: the facility has a policy regarding first responder duties and have appropriately trained staff in the requirements of responding to a sexual abuse claim in order to protect the victim and preserve evidence. The auditor reviewed documentation of staff first responder training and the curriculum for the training. The facility has also created an Emergency Response Plan.

§115.264 (b) Meets standard

§115.264 (b) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

In order to make a determination of compliance, the following policies and other documentation were reviewed: Policy 115.254.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Security staff and non-security staff first responders and a random sample of staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: the facility has a policy regarding first responder duties and have appropriately trained staff in the requirements of responding to a sexual abuse claim in order to protect the victim and preserve evidence. The auditor reviewed documentation of staff first responder training and the curriculum for the training. The facility has also created an Emergency Response Plan to be used as a guideline should there

be an incident in the facility. Interviews with staff indicate that they are familiar with the guidelines of this provision although most staff members indicated that they would call the Facility Director for guidance. When questioned further, staff was able to articulate the requirements.

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)

115.265 The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.265 and the Emergency Response Plan.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has developed an emergency response plan. The plan coordinates actions taken in response to an incident of sexual abuse, among staff first responders, mental health practitioners, investigators, and facility leadership. CAAP does not employ an Medical staff.

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)

§115.266(a) – Meets Standard

§115.266(a) Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

In order to make a determination of compliance, the following policies and other documentation were

reviewed: 115.266.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAP does not enter into any agreements that do not meet the requirements of the standards.

§115.266(b)- Non-Applicable

§115.266(b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern:

(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the
provisions of 115.272 and 115.276; or

(2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following determination that the allegation of sexual abuse is not substantiated.

Not Applicable.

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)

§115.267(a)

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.267.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head, Designated Staff Member Charged with monitoring retaliation.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has assigned a staff member to be responsible for monitoring retaliation. When interviewed the staff member was familiar with her responsibilities as the retaliation monitor. Policy 115.267 Section A (a) CAAP policy is to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.

§115.267(b) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.267.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head, Designated Staff Member Charged with monitoring retaliation.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Layout of facility allows for limited separation.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. The facility also has two separate dorms for allowing for separations as needed.

The PREA Coordinator indicated that the facility would do what was required to protect the abused. This would include housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

§115.267(c) Meets Standard

§115.267(c) For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

In order to make a determination of compliance, the following policies and other documentation were

reviewed: 115.267.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager and Designated Staff Member Charged with monitoring retaliation.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. Interviews with the director and Designated Staff Member Charged with monitoring retaliation confirm that they will monitor for a minimum of 90 days or for as long as needed to provide protection.

§115.267 (d) Meets Standard

§115.267 (d) In the case of residents, such monitoring shall also include periodic status checks.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.267.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager and Designated Staff Member Charged with monitoring retaliation.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Both the Program Manager and the Designated Staff Member Charged with monitoring retaliation confirm that they will make periodic checks of residents to monitor for retaliation.

§115.267 (e) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.267.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head, Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to protect individuals who cooperate with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. The auditor was unable to verify compliance through reports, as there have not been any cases that qualified or required retaliation monitoring. The Program Manager indicated in the interview that precautions would be made to protect anyone that is involved in an investigation of sexual abuse or sexual harassment.

§115.267 (f) Meets Standard

§115.267 (f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.267.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Agency Head, Director.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to protect individuals who cooperate with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. The agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

The auditor was unable to verify compliance through reports, as there have not been any cases that qualified or required retaliation monitoring. The Program Manager indicated in the interview that precautions would be made to protect anyone that is involved in an investigation of sexual abuse or sexual harassment.

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)

§115.271 (a) Meets Standard

§115.271 (a) When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third party and anonymous reports.

In order to make a determination of compliance, the following policies and other documentation were

reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. Policy 115.271 states, "CAAP does not conduct sexual abuse investigations. In the case of sexual abuse the MEMPHIS POLICE DEPARTMENT will be responsible to perform the investigation. However, facility staff indicated that they would investigate Administrative cases.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Policy 115.271 states, "CAAP does not conduct sexual abuse investigations. In the case of sexual abuse the MEMPHIS POLICE DEPARTMENT will be responsible to perform the investigation. However, facility staff indicated that they would investigate Administrative cases.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. The facility shall investigate Administrative sexual abuse and sexual harassment incidents promptly, thoroughly, and objectively for all allegations, including third party and anonymous reports. Policy 115.271 states, "CAAP does not conduct sexual abuse investigations. In the case of sexual abuse the MEMPHIS POLICE DEPARTMENT will be responsible to perform the investigation. However, facility staff indicated that they would investigate Administrative cases.

Update: CAAP has revised their policy to indicate that the Memphis Police Department will conduct all Sexual Abuse investigations in their facility

§115.271 (b) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. The policy does state: Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to§ 115.234. CAAP has indicated that Memphis Police Department will be utilized to investigate sexual abuse incidents.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAPs turns all sexual abuse investigations over to the Memphis Police Department for investigation.

§115.271 (c) Meets Standard

§115.271 (c) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. Section C of this policy states, "Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator." Memphis Police Department would conduct these investigations.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Section C of policy 115.271 states, "Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator." Memphis Police Department would conduct these investigations. However, the auditor was unable to review any reports for compliance, as the facility has not had any PREA complaints to date.

§115.271 (d) Meets Standard

§115.271 (d) When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Policy Section (d) states, "When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution." However, the auditor was unable to review any reports for compliance, as the facility has not had any PREA complaints to date.

§115.271 (e) Meets Standard

§115.271 (e) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual

basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth- telling device as a condition for proceeding with the investigation of such an allegation.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. CAAP does not conduct sexual abuse investigations. In the case of sexual abuse the MEMPHIS POLICE DEPARTMENT will be responsible to perform the investigation.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility did not have any PREA related reports to review. CAAP does not conduct sexual abuse investigations. In the case of sexual abuse the MEMPHIS POLICE DEPARTMENT will be responsible to perform the investigation.

§115.271 (f) Meets Standard

§115.271 (f) Administrative investigations:

(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and
(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. Policy 115.271section f states: "(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; And (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings."

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy to include an effort to determine whether staff actions or failures to act contributed to the abuse and to document in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; however the facility has not properly trained their investigative staff. The auditor was unable to review any reports for compliance as the facility has not had any PREA complaints to date.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification

of full and successful implementation of corrective measure(s) can be accomplished. Staff investigators shall be properly trained to conduct Administrative Investigations.

Update: Memphis Police Department will conduct all Sexual Abuse investigations.

§115.271 (g) Meets Standard

§115.271 (g) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. The Sexual Misconduct Policy g states: "When the agency conducts its own investigations into allegations of sexual misconduct, it will do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.;"

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The Policy Section g states: "When the agency conducts its own investigations into allegations of sexual misconduct, it will do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.;" Interviews with the investigative staff indicated that staff would only conducts its own investigations into administrative allegations of sexual harassment and it will do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports; the facility has properly trained their investigative staff. However, the auditor was unable to review any reports for compliance, as the facility has not had any PREA complaints to date.

§115.271 (h) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. Policy indicates that the Memphis Police Department.(MPD) will investigate all criminal cases. MPD would contact the prosecutor for referral.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility did not have any PREA related reports to review. Policy indicates that the Memphis Police Department.(MPD) will investigate all criminal cases. MPD would contact the prosecutor for referral.

§115.271 (i) Meets Standard

§115.271 (i) The agency shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. The Policy Section I states, "i) The agency shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: Policy requires the agency to maintain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The facility has not had any PREA cases to date.

§115.271 (j) Meets Standard

§115.271 (j) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states, "The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation;" Interviews with Investigative staff confirm that they are familiar with the policy and protocol should the victim or perpetrator depart the facility or employment.

§115.271 (k) Non-Applicable

§115.271 (k) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

Non-Applicable

§115.271 (l) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.271.

In order to make a determination of compliance, the following people were interviewed: Investigative staff, Director, PREA Coordinator, Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None. The facility did not have any PREA related reports to review. The Policy Section requires staff to cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The policy requires the agency to cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. There were not previous investigations to review.

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)

§115.272 Meets Standard

§115.272 The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.272.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative staff.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The policy states, "CAAP shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Investigative staff interviewed was not familiar with the preponderance of the evidence as the standard for the investigation.

The following corrective measure(s) are recommended for action during the corrective action period. The

agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. Staff investigators shall be properly trained to conduct Administrative Investigations.

Update: CAAPs has trained their staff to follow the standard of Preponderance of the evidence as the guide in determining whether allegations of sexual abuse or sexual harassment are substantiated

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)

§115.273(a) Meets Standard

§115.273(a) Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.273.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The policy states, "Following an investigation into a resident's allegation of sexual misconduct suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded."

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states, "Following an investigation into a resident's allegation of sexual misconduct suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded." Interviews with investigative staff indicate that they would notify the victim when the case investigation has been completed. There were no completed cases for review.

§115.273(b) Meets Standard

§115.273(b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.273.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Investigative Staff.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The policy states, "Following an investigation into a resident's allegation of sexual misconduct suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded."

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states, "Following an investigation into a resident's allegation of sexual misconduct suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded." Interviews with investigative staff indicate that they would notify the victim when the case investigation has been completed. There were no completed cases for review.

§115.273(c) Meets Standard

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

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.273.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The policy states, "Following a resident's allegation that a staff member has committed sexual misconduct against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:

a. The staff member is no longer employed at the facility;
b. The agency learns that the staff member has been indicted or convicted of a charge related to sexual misconduct within the facility."

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that covers this provision. There were no completed cases for review.

§115.273 (d) Meets Standard

§115.273 (d) Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:

(1) The agency learns that the alleged abuser has been indicted on a charge related to

sexual abuse within the facility; or
(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.273.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: The auditor was unable to locate anyone that had reported a case of sexual abuse in the facility.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states, "Following a resident's allegation that she has been involved in an incident of sexual misconduct by another resident, the agency shall subsequently inform the alleged victim whenever the agency learns that the alleged abuser has been indicted or convicted on a charge related to sexual misconduct within the facility." The auditor did interview the investigative staff and the PREA Coordinator who agreed that they would notify the victim as required. There were no completed cases for review.

§115.273(e) Meets standard

§115.273(e) All such notifications or attempted notifications shall be documented.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.273.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None, There were no logs to review as there have not been any cases where the victim was to be notified.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy in place to address this provision. The auditor was unable to verify that this is being practiced, as there were no cases or logs to review. Interview with PREA Coordinator confirmed that they would document the notification.

§115.273(f) Meets Standard

§115.273(f) and agency's obligation to report this standard under this standard shall terminate if the resident is released from the agency's custody.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.273.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None, There were no logs to review as there have not been any cases where the victim was to be notified.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy in place to address this provision. Interview with PREA Coordinator confirmed that they would terminate if the resident is released from the agency's custody.

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)

§115.276 (a) Meets Standard

§115.276 (a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.276.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The policy states, "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 resignations, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies." The Program Manager also confirmed that staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

§115.276 (b) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.276.

In order to make a determination of compliance, the following people were interviewed: Program Manager and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states, “Termination from employment shall be the presumptive disciplinary sanction for staff members who have engaged in sexual abuse;” However, the auditor was unable to review any records of terminations, disciplinary actions or other sanctions for violation of sexual abuse or harassment as there were no cases reported.

§115.276 (c) Meets Standard

§115.276 (c) Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.276.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states, “Termination from employment shall be the presumptive disciplinary sanction for staff members who have engaged in sexual abuse;” and “Disciplinary sanctions for violations of agency policies relating to sexual misconduct (other than actually engaging in sexual abuse) will 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.” However, the auditor was unable to review any records of terminations, disciplinary actions or other sanctions for violation of sexual abuse or harassment as there were no cases reported.

§115.276 (d) Meets Standard.

§115.276 (d) All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.276.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states, "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 resignations, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies." The auditor was unable to review any records of referral to law enforcement as there were no cases reported.

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)

§115.277 (a) Meets standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.277.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: No records to review.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy in place to address this provision of the standard. It states, "Staff Sexual Misconduct: Any behavior or act of a sexual nature whether it be consensual or non-consensual directed toward a resident by an employee, contractor, volunteer, visitor, or other agency representative. Termination from employment shall be the presumptive disciplinary sanction for staff members who have engaged in sexual abuse; prohibition from contact with residents will be the presumptive measure for contractors, volunteers, visitors, or other agency representatives who have engaged in sexual abuse. CAAP Inc. will investigate allegations with the SART Team if any findings or previous findings of sexual abuse or sexual harassment there will be no contemplating the contractor or volunteer will be prohibited from the agency indefinitely. There were no records to review.

§115.277 (b) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.277.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: No records to review.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy in place to address this provision of the standard. CAAP Inc. will investigate allegations with the SART Team if any findings or previous findings of sexual abuse or sexual harassment there will be no contemplating the contractor or volunteer will be prohibited from the agency indefinitely. There were no records to review.

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)

§115.278 (a) Meets Standard

§115.278 (a) Residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.278.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does have a policy that covers this provision. The procedure states, The administrative find that resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse there will be subject to disciplinary action, which could be reason for discharge from the program.

§115.278 (b) Meets Standard

§115.278 (b) Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.278.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does have a policy that covers this provision. It states, Action will be appropriate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the actions imposed for similar offenses by other residents with alike(sic- similar) histories.

§115.278 (c) Meets standard

§115.278 (c) The disciplinary process shall consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.278.

In order to make a determination of compliance, the following people were interviewed: Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does have a policy that covers this provision. It states, “The penalizing process will consider whether a resident's mental disabilities or mental illness contributed to her behavior when determining what type of actions, if any, should be imposed. The Program Manager reaffirmed this policy.

§115.278 (d) Meets Standard

§115.278 (d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

CAAP does not offer therapy, counseling or interventions designed to address and correct the underlying reasons or motivations for abuse, the facility considers whether to require the offending residents to participate in such interventions as a condition of access to programming or other benefits.

§115.278 (e) Meets Standard

§115.278 (e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.278.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy CAAP is not responsible for discipline(ing) a resident for sexual contact with staff after finding that the resident information was not true. The proper authority sanctions residents for unfound allegations. CAAP does have a disciplinary process and could discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact; However, since CAAP is a community Confinement facility, an offender accused of sexual contact with a staff member would be removed from the program and returned to prison or turned over to her probation officer for adjudication.

§115.278 (f) Meets standard

§115.278 (f) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.278.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy states, CAAP prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation." The PREA Coordinator reaffirmed this policy.

§115.278 (g) Meets Standard

§115.278 (g) An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.278.

In order to make a determination of compliance, the following people were interviewed and the following

interview findings were considered: None.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy states, "CAAP prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced." The auditor reviewed disciplinary actions and grievances and did not find any disciplinary actions pertinent to this provision.

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)

§115.282 (a) Meets Standard

§115.282 (a) Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.282.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Medical and Mental Health Staff. The auditor was unable to locate any residents that had reported a case of sexual abuse.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The facility does not have a nurse or counselor on staff. Emergency medical assistance would be provided if needed, at the local hospital. All crisis intervention services would be provided by the Family Safety Center or by the local hospital.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAPs Residents are sent to the nearest local community Hospital without financial cost. The Program Manager and PREA Coordinator concurred that the Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

§115.282 (b) Meets Standard

§115.282 (b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to § 115.262 and shall immediately notify the appropriate medical and mental health practitioners.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.282.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Security Staff and Non-Security Staff First Responders.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: The facility does not have Medical or Mental Health on staff. Counselors that are available to residents. Emergency medical assistance would be provided off site, at the local hospital. All crisis intervention services would be provided by the Family Safety Center or by the local hospital.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility does not have Medical or Mental Health on staff. Counselors that are available to residents. Emergency medical assistance would be provided off site, at the local hospital. All crisis intervention services would be provided by the Family Safety Center or by the local hospital. The policy states, "Resident victims of sexual abuse will receive timely, unimpeded, and ongoing access to emergency medical treatment and crisis intervention services, including follow-up medical and mental health services, as recommended by medical and mental health practitioners according to their professional judgment. Emergency and follow-up services should include but are not limited to the potential of sexually transmitted infections and pregnancy. The agency will refer any resident victims to a victim advocate from the local rape crisis center or the Family Safety Center.

§115.282 (c) Does Not Meet Standard

§115.282 (c) Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.282.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy states, "Resident who is victims of sexual abuse while in the facility shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. (N/ A)" (all female staff and residents) While the residents may not become pregnant and possibly need access to emergency contraception, they may be subject to being infected with a sexually transmitted disease and should be afforded sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished. Residents who are

victims of sexual abuse while in the facility shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Even though CAAPs is currently an all female staff facility, there are male contractors that enter the facility from time to time and in the future, there could be an occasion when the agency hires a male staff member. The policy should be revised.

Update: Policy 115.282 was revised to reflect that residents would be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

§115.282 (d) Meets Standard

§115.282 (d) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.282.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy states, "(d) CAAP will provided treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." Treatment services will be provided to resident victims without cost. This was confirmed solely through policy and interviews with the PREA Coordinator and Program Manager as there have not been an incidents where these services needed to be offered.

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)

§115.283 (a) Meets Standard

§115.283 (a) The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.283.

In order to make a determination of compliance, the following people were interviewed and the following

interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy states, “The facility do not offer medical and mental health evaluations or treatment, residents are sent to the local community hospitals and mental health providers.” There were no examples of a need for a medical or mental health evaluation treatment as there have not been any victims of sexual abuse at this facility.

§115.283 (b) Meets Standard

§115.283 (b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.283.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator, Program Manager. The auditor was unable to locate any residents that had reported an incident of sexual abuse.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: CAAP policy states they will notify the medical and mental health staff about evaluation and treatment of such victims shall include, as appropriate, follow-up services, Treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody and document response.

§115.283 (c) Meets Standard

§115.283 (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.283.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor interviewed the Program Manager and the PREA Coordinator to determined that the facility would provide care consistent with the community level of care, by utilizing community care.

The facility does not employ any Mental Health or Medical staff.

§115.283(d)- Meets Standard

§115.283(d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.283.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor interviewed the Program Manager and the PREA Coordinator to determined that the facility would offer pregnancy tests to resident victims of sexually abusive vaginal penetration while incarcerated.

§115.283 (e)- Meets Standard

§115.283 (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.283.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor interviewed the Program Manager and the PREA Coordinator to determined that the facility would provide timely and comprehensive information about and timely access to all lawful pregnancy related medical services.

§115.283 (f) Meets Standard

§115.283 (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.283.

In order to make a determination of compliance, the following people were interviewed and the following

interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor interviewed the Program Manager and the PREA Coordinator to determined that the facility would provide (f) an outside provider and offered tests for sexually transmitted infections as medically appropriate.

§115.283 (g) Meets Standard

§115.283 (g) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.283.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has a policy that states, CAAP will provide treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The PREA Coordinator and Program Manager confirmed that the services would be provided without financial costs to the victim whether the victim names the abuser or cooperates with any investigation arising out of the incident.

§115.283 (h) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.283.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility policy states, "CAAP will conduct a mental health evaluation of all known residents-on-residents abusers within 60 days of learning of such abuse history, and offers treatment when deemed appropriate by mental health practitioners. While CAAP does not provide these services

on site, residents would be sent to the local community hospitals and mental health providers as needed.

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)

§115.286(a) Meets Standard

§115.286(a) The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.286.

In order to make a determination of compliance, the following people were interviewed: Program Manager and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The interview with the Program Manager and PREA Coordinator revealed that the facility has established an Incident Review Team. I interviewed several members of the team. While they have not had any incidents to date, the team is prepared to conduct a review within 30 days of an incident.

§115.286 (b) Meets Standard

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

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.286.

In order to make a determination of compliance, the following people were interviewed: Program Manager and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The interview with the Program Manager and PREA Coordinator revealed that the facility has established an Incident Review Team. I interviewed several members of the team. While they have not had any incidents to date, the team is prepared to conduct a review within 30 days of an incident.

§115.286 (c) Does Not Meet Standard

§115.286 (c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.286.

In order to make a determination of compliance, the following people were interviewed: Program Manager and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The interview with the Program Manager and PREA Coordinator revealed that the facility has established an Incident Review Team. I interviewed several members of the team. While they have not had any incidents to date, the team is prepared to conduct a review within 30 days of an incident. The Incident review team includes supervisors and investigators. The facility does not employ any Medical or Mental Health staff.

§115.286 (d) Meets Standard

§115.286 (d) The review team shall:

(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
(4) Assess the adequacy of staffing levels in that area during different shifts;
(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement, and submit such report to the facility head and PREA compliance manager.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.286.

In order to make a determination of compliance, the following people were interviewed: Program Manager and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The interview with the Program Manager and PREA Coordinator revealed that the facility has established an Incident Review Team. I interviewed several members of the team. While they have not had any incidents to date, the team is prepared to conduct a review within 30 days of an incident and

would consider the above criteria during their review of the incident.

Recommendation:

Best practices would be to create a form to use in the event there is an incident so you can ensure that the required criteria are reviewed and documented as you will need to provide documentation that the required criteria was reviewed if you have an incident.

§115.286 (e) Meets Standard

§115.286 (e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.286.

In order to make a determination of compliance, the following people were interviewed: Program Manager and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The interview with the Program Manager and PREA Coordinator revealed that the facility has established an Incident Review Team. I interviewed several members of the team. While they have not had any incidents to date, the team is prepared to conduct a review within 30 days of an incident. The team is prepared to review the required criteria and to implement recommendations for improvement or document its reason for not doing so.

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)

§115.287 (a) Meets Standard

§115.287 (a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.287.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has not collected accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by September 2016.

The facility shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

Corrective Action Completed:

CAAPs have developed a mechanism for tracking PREA incidents using a standardized instrument and a set of definitions. I have reviewed the documents for accuracy.

§115.287 (b) Meets Standard

§115.287 (b) The agency shall aggregate the incident-based sexual abuse data at least annually.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.287.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has not collected accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The data should be aggregated annually.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by September 1, 2016.

The facility shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The facility shall aggregate the incident-based sexual abuse data at least annually.

Corrective Action Completed:

The facility has collected accurate, uniform data for every allegation of sexual abuse in their facility. The data was aggregated in written form.

§115.287 (d) Meets Standard

§115.287 (d) The agency shall maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.287.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The auditor has determined that the facility is not in compliance with the elements of this provision. The facility has established a policy for maintaining, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews. However, the facility has not yet implemented this practice. Even if the numbers are zero, a report should be generated that indicated there were no incidents of sexual abuse or sexual harassment.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by September 1, 2016.

Develop a process to maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.

Corrective Action Completed:
The facility has developed a process to maintain, review and collect data needed from all incident-based documents including reports, investigation files and sexual abuse incident reviews. The facility store and preserves all PREA related incident related documentation in one file and an annual report is generated from the data.

§115.287 (e) Non-Applicable

§115.287 (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

N/A as the agency does not contract for the confinement of its residents.

§115.287 (f) Non-Applicable

§115.287 (f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The Department of Justice has not yet requested any data from the previous calendar year.

☐ 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)

§115.288 (a) Meets Standard

§115.288 (a) The agency shall review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:

(1) Identifying problem areas;
(2) Taking corrective action on an ongoing basis; and
(3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.288.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Director and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has established a policy to collect, maintain, and review accurate uniform data for every allegation of sexual misconduct using the Survey of Sexual Violence by the Department of Justice. This data should be compiled annually and maintained for a minimum of ten years after the date of its initial collection. However, no annual reports have been created or reviewed and aggregated as required.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by September 1, 2016

Review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: (1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.

Update: CAAP has completed an annual report for 2016.

§115.288 (b) Meets Standard

§115.288 (b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.288.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Director and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has established a policy to collect, maintain, and review accurate uniform data for every allegation of sexual misconduct using the Survey of Sexual Violence by the Department of Justice. This data should be compiled annually and maintained for a minimum of ten years after the date of its initial collection. However, no annual reports have been created or reviewed and aggregated as required.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have/will collaborate to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by September 1, 2016

Create a report comparing the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse**.**

Update: CAAP has completed an annual report for 2016 that compares the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.

§115.288 (c) Meets Standard

§115.288 (c) The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.288.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Director and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has not created an agency report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by September 1, 2016.

Create a report comparing the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse. The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.

Update:
The annual report is approved by the agency head and made available on the facility website.

§115.288 (d) Meets Standard

§115.288 (d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.288.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Director and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has not created an agency report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means. Thus they may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by September 1, 2016.

Create an agency report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means. Thus they may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

Update: CAAP has created an annual PREA report no data that would be a specific threat to the safety and security of a facility, but must indicate the nature of the material is contained in the report.

Standard §115.289 Data Storage, Publications, 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)

§115.289 (a) Meets Standard

§115.289 (a) The agency shall ensure that data collected pursuant to §115.287 are securely retained.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.289.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Files are secured in the PREA Coordinator's office. The files are locked when the coordinator is not present.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility secures data collected pursuant to §115.287. These files are secured in the Coordinator's office under lock and key when the she is not present.

§115.289 (b) Meets Standard

§115.289 (b) The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means.

In order to make a determination of compliance, the following documents were reviewed: None.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: PREA Coordinator and Program Manager.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: Reports are not listed on their Website.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has not yet posted any annual reports on their website as required.

The following corrective measure(s) are recommended for action during the corrective action period. The agency and auditor have collaborated to identify deliverables and a timeline for them so that verification of full and successful implementation of corrective measure(s) can be accomplished by September 1, 2016.

Once the reports have been created, they should be posted on the facility website so they are accessible to

the public.

Update: Reports have been posted online at http://www.caapincorporated.com/community-corrections-service/.

§115.289 (C) Meets Standard

§115.289 (C) Before making aggregated sexual abuse data publicly available; the agency shall remove all personal identifiers.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.288.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Director and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has not created an agency report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means. Thus they may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted. The facility does have a policy in place to follow this protocol, but have not yet created any reports to date.

§115.289 (D) Meets Standard

§115.289 (D) The agency shall maintain sexual abuse data collected pursuant to 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise.

In order to make a determination of compliance, the following policies and other documentation were reviewed: 115.288.

In order to make a determination of compliance, the following people were interviewed and the following interview findings were considered: Program Director and PREA Coordinator.

In order to make a determination of compliance, the following observations were made during my on-site tour of the facility: None.

The following describes how the evidence above was used to draw the final conclusion regarding compliance: The facility has not created an agency report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means. Thus they may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted. The facility does have a policy in place to follow this protocol, but have not yet created any reports to date. All reports will be maintained for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of her knowledge and no conflict of interest exists with respect to her ability to conduct an audit of the agency under review.

______________________________Auditor Signature Date: November 17, 2016

Melinda D. Allen

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