AUDIT FINDINGS

NARRATIVE

Chrysalis House, Inc. located in three (3) separate locations/sites: 120 Chrysalis Court; 251 E. Maxwell Street; and 1588 Hill Rise Drive, Lexington Kentucky 40504 is a 48-bed long-term recovery program (Alcohol/or Drug Rehabilitation Program for women) that has received CARF International accreditation (Commission on Accreditation of Rehabiliation). Chrysalis House, Inc. is in their 38th year of service (the oldest and largest licensed (currently employs five (5) licensed mental health therapist and one (1) domestic violence therapist) women's substance abuse program in the state of Kentucky. Chrysalis House, Inc. provides a safe, nurturing, and aesthetically pleasing environment for adult recovering women and their children, recognizing the disease concept of addiction and incorporating the Twelve Step Programs while also infusing Evidence Based Practices into every aspect of treatment programming. Addictions and mental health disorders affect every aspect of a woman's functioning, and the "whole" woman must be treated in order to achieve health, happiness, and serenity. The mission and vision of Chrysalis House, Inc. is to help and support women and their families that are recovering from alcohol and other drug abuse to lead sober, independent lives that are socially, physically, emotionally, and spiritually stable. Chrysalis House, Inc. has several funding sources that include federal funds, Kentucky State funds (including Kentucky Department of Corrections), local funds, grants, private donations, sponsors, and fundraisers. Residents are referred from several referral sources including Kentucky Department of Corrections, Drug Court/family court judges; Kentucky Department of Community Based Services, hospitals and/or other treatment facilities, and volunteers. Residents come into Chrysalis House, Inc. not in need of being detoxed for substance abuse and, when applicable, showing prescription medication adherence for both physical and mental health conditions, which plays a key role in the treatment of those with co-occurring disorders. Each new resident will be placed in the Orientation Phase of the program, is presented with a treatment team that includes but is not limited to: a licensed therapist, a case manager, support staff, the Job Readiness Coordinator, the Housing Coordinator, and the resident will develop an Individualized Treatment Plan. All residents are subject to random urine drug screens throughout their stay. Residents transition through levels of care/different phases (Orientation Phase through Phase 4-Aftercare/Independent Living) based on specific goals and objectives. Chrysalis House, Inc. offers a number of groups and activities including but not limited to: Big Book Study, Morning and Evening House Meetings, Corrective Thinking, Nurturing Families, Mother/Child Attachment, 12 Step Support Group, Relapse Prevention, Relationships, Seeking Safety, Wise Minds, Computer Skills, GED Tutoring, Job Readiness, Process Group, Adult Daily Living Skills, Addictions 101, Domestic Violence Education, In-house AA meeting, Positive Social and Communications Skills, Self-Care & Coping; Acceptance & Recovery, Motivated to Change, Family Education Groups/Family Meetings, Individual Therapy, Case Management. Chrysalis House, Inc. utilizes students/interns/volunteers that must be approved to work with the residents (same application process as staff that work at Chrysalis House, Inc. including but not limited to submit to a criminal background check/TB Skin Test/urine drug screens) and the Clinical Director is responsibility for maintaining the integrity and quality of the student/intern/volunteer training program. The facility currently has 48 female residents (age 18 years and over) in three separate locations (sites). The facility employs 31 female staff (including five (5) licensed mental health therapist, one (1) domestic violence therapist, four (4) case managers, and 1 full-time male staff (Facilities Management/maintenance) that travel from facility site to site to provide full coverage of services.

This audit was conducted by DOJ Certified PREA Auditor Tina Sallee. During the Pre-Audit phase the auditor reviewed a variety of documents provided by the facility. These included policies and procedures, plans, protocols, training records, curricula, and other documents related to demonstrating compliance with the PREA Standards. The auditor did not receive any correspondence or requests from staff or residents prior to the on-site audit (a notice was posted with contact information for the PREA Auditor/audit date six weeks prior to the on-site audit).

An on-site PREA Audit was conducted on Thursday, August 4, 2016. An entrance meeting was held with Lisa Minton, Executive Director; Tonya Jernigan, Clinical Director/PREA Coordinator; and Jennifer Stamper, Treatment Director/Safety Officer. The on-site audit work plan was discussed, samples of residents and staff were selected, and specialized staff were identified. Also, additional pre-audit information was obtained. Following the entrance meeting a tour of the facility's three (3) locations was led by Jennifer Stamper, Treatment Director/Safety Officer. Three separate locations (Chrysalis Court; Maxwell; Hill Rise) were fully viewed including administration areas, classrooms and meeting areas, visitation areas/common areas, kitchens and dining areas, recreational and outside areas, and housing units/bathrooms. PREA-related informational posters and the PREA audit notice were observed posted. Additionally, informational pamphlets and posters regarding PREA and the Sexual Assault Crisis Services locally Bluegrass Rape Crisis Center, were found in areas where staff and residents had access. Pamphlets and posters are printed in English (but if needed Limited English Proficiency (LEP) services are made available as necessary). No SAFE or SANE staff are employed at the facility; however, these professionals are provided at the University of Kentucky Emergency Room where forensic examinations would be conducted at no cost to the resident and/or their families.

Interviews were conducted with Lisa Minton, Executive Director; Tonya Jernigan, Clinical Director/PREA Coordinator; Jennifer Stamper, Treatment Director/Safety Officer; Jessica White, Admissions and Transitions Coordinator (conducts facility intake and also completes risk assessment tool); one (1) support staff/student; and three (3) female residents (one resident identified as being bi-sexual during intake/risk assessment) randomly selected.

There have been zero (0) allegations/investigations of sexual harassment/sexual abuse in the previous 12 months. But the agency with the authority to conduct criminal investigations would be Kentucky Department of Corrections and/or Kentucky State Police. Per agency

policy and staff interviews all allegations of sexual harassment/sexual abuse have to be reported to the agency with the authority to conduct investigations.

The majority of the female residents admitted to this facility have indicated a history of being physically and/or sexually abused during the intake process (while completing an assessment tool, to ascertain risk of being sexually victimized and/or abusive). One (1) of the female residents selected for interview identified as being gay and/or bisexual during the intake process/risk assessment. The resident reported that she had not been treated any differently than the other residents at this facility and was very complimentary regarding her feelings regarding this facility. There was no resident identified as hearing or visually impaired, or who had limited English proficiency to interview this date.

Documentation and interviews confirmed that all residents do receive information on PREA and their right to not be sexually abused/harassed, how to report sexual abuse/harassment, their right not to be punished for reporting such immediately upon arriving at the facility. Residents are assessed during intake process to ascertain risk of being sexually victimized and/or abusive and the facility uses this information to keep residents safe. Additionally, after residents are admitted into the facility they are provided additional information about sexual abuse/harassment during weekly meetings, pamphlets and posters. Residents who have experienced trauma, abuse, or victimization are provided mental health services, as needed, through local organization and/or utilize the five (5) licensed mental health therapist and one (1) domestic violence therapist that are current staff of Chrysalis House, Inc.

DESCRIPTION OF FACILITY CHARACTERISTICS

Chrysalis House, Inc. is located in Lexington, Kentucky. The tour of the facility was conducted by Jennifer Stamper, Treatment Director/Safety Officer. The facility was housed in three (3) separate locations/sites in Lexington: Chrysalis Court (which houses 20 female residents); Maxwell (which houses 14 female residents); and Hill Rise (which houses 14 female residents). The buildings are spacious enough for the staff and the residents. Each of the buildings had offices/central monitoring stations/monitored entrances. Each of the sites had classrooms/meeting areas, visitation areas and common areas. Each of the sites had laundry facilities, kitchens, dining areas, and outdoor areas (including smoking areas). Each of the buildings had multi-occupancy bedroom(s)(with 1, 2 or 3 residents per bedroom depending on the size of the bedroom) and bathrooms – with showers, (shower curtains over the showers), toilets (doors on toilet stalls), and sinks.

The PREA Audit notice and posters containing PREA information including the PREA hotline number are prominently posted on bulletin boards, dining area, hallways, and classrooms/meeting rooms.

There has been no significant modifications made to this facility since August 20, 2012. There are currently no cameras at Chrysalis House, Inc. community confinement residential facility but agency/facility continues having on-going discussions regarding adequate levels of staffing and/or future possibility of utilizing video monitoring in order to continue to protect both residents and staff from sexual harassment/sexual abuse and/or allegations of such. Interviews confirm that any modifications/updating to the facility in future would be based on the practice of considering the effect upon the facilities ability to protect residents and staff from sexual harassment/sexual abuse and/or allegations of sexual harassment/sexual abuse.

SUMMARY OF AUDIT FINDINGS

The first PREA community confinement facility audit of the Chrysalis House, Inc. housed in three (3) separate locations/sites in Lexington, Kentucky was conducted on Thursday, August 4, 2016. The audit consisted of data review, staff and resident interviews and facility tour and observations. Documents were timely and complete and included resident assessment forms, resident education acknowledgment forms completed during intake process, staff background screening information as well as staff PREA training records. Staff and resident interviews occurred efficiently. The entire facility was toured. Overall, the facility was well prepared for the audit and performed well in all areas.

Number of standards exceeded: 1

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 3

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

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a written policy mandating zero tolerance toward all forms of sexual harassment and/or sexual abuse in the facility. The policy details the approaches it uses to prevent, detect and respond to sexual harassment and/or sexual abuse in the facility. The definitions of prohibited behaviors are clearly defined, as are the sanctions for those who violate the policy. Policy is thorough and mirrors the PREA language. Policy is in use and staff were able to explain it to the auditor when asked.

The facility has designated an Agency-Wide PREA Coordinator, Tonya Jernigan. She is knowledgeable of PREA requirements/standards, devotes sufficient time and effort in assisting facility staff with PREA-related topics, and has the authority to implement corrective actions and to coordinate the facility's compliance with the PREA community confinement standards.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NOT-APPLICABLE – this facility does not contract for the confinement of its 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)

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

In the past 12 months there have been zero (0) allegations/investigations of sexual harassment/sexual abuse. Staff interviewed voiced that the

physical layout of the facility, the composition of the resident population, and other relevant factors are used to calculate adequate staffing levels and to determine needs for further technologies, on an ongoing basis for the safety of the residents and the staff. The facility policy meets all the elements of the standard. The staffing plan has been completed and meets all the elements of the standard. Staff and resident interviews and documentation confirmed the practice of supervision and monitoring.

Standard 115.215 Limits to cross-gender viewing and searches

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

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

(a)-(b) There are NO CROSS GENDER strip searches permitted (this is a non-medical facility). There are only female residents and female staff at this facility. (c) There are NO CROSS GENDER pat searches permitted. There are only female residents and female staff at this facility. (d) All residents have the ability to shower/perform bodily functions/change clothes without being viewed by staff. All toilets have doors and all showers have curtains. (e) Not Applicable – there have been NO transgender or intersex residents admitted to date. The facility policy prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. (f) All staff are trained in using a professional and respectful manner with transgender and intersex residents per documentation of training and staff reports during interviews (even though they have not had to address this issue to date) they have received training.

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

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

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

Policy has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual harassment/sexual abuse but there were no residents with disabilities or LEP to interview at this time. If it is determined that residents have limited reading skills, intake and/or screening staff will read the written materials to the residents.

Standard 115.217 Hiring and promotion decisions

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The facility conducts extensive background checks and reference checks with multiple entities. There is a policy to conduct background checks verified through documentation and staff interviews. The facility policy addresses all of the elements of this standard.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has NOT made a substantial expansion or modification to existing facility since August 2012. Interviews with the Executive Director, the Clinical Director/PREA Coordinator, and the Treatment Director/Safety Officer confirmed that any and all modifications/updating to the facility in future will be based on the practice of considering the effect upon the facilities ability to protect residents and staff from sexual harassment/abuse and/or allegations of sexual harassment/abuse.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a)-(b) The facility does not conduct administrative or criminal investigations. The name of the agency that has responsibility would be Kentucky Department of Corrections and/or Kentucky State Police. (c)-(h) The facility offers contact information for local Bluegrass Rape Crisis Center. Forensic medical exams, when needed, would be conducted at University of Kentucky Emergency Room, at no cost to the resident or to the resident's families.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility policy ensures that an administrative/criminal investigation is completed on all allegations of sexual harassment/abuse. The facility policy requires that all allegations that are criminal in nature are reported to the Kentucky State Police, an agency with the legal authority to conduct criminal 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)

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

Documentation and staff interviews indicated that all current staff have completed PREA Training (training included all 10 elements of the subsection) and staff have signed acknowledgment forms (documentation through employee signature that employees received the training). That training is tailored to the gender of the residents and that staff can receive additional training if needed, that all employees are made aware of the facility's no tolerance for sexual harassment/abuse policies and procedures.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy meets the requirements of the standard. The facility does utilize volunteers, vendors, and contractors, and all are required to complete the PREA training. The facility maintains documentation/acknowledgement forms confirming that volunteers, vendors and contractors sign stating that they understand the PREA training that they have received on their responsibilities under the facility's sexual harassment/abuse prevention, detection, and response policies and procedures.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility policy is thorough and mirrors the PREA language. PREA education is conducted during intake/assessment process with pamphlets, posters on bulletin boards, residents handbooks and documentation of the residents participation in these education sessions with resident signatures verifying they understand the facility's zero-tolerance policy regarding sexual harassment/abuse. Residents acknowledged during interviews that they do receive the education upon entering the facility, that they understood their rights to be free from sexual harassment/abuse and their right to be free from retaliation for reporting such incidents. Residents were able to discuss various ways they can report an allegation and/or receive services if needed. The agency does provide residents education in formats accessible to all, including those who are limited English proficient or handicapped (but there were no residents to interview at this time with either).

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is NOT-APPLICABLE. This facility does NOT conduct administrative or criminal investigations. The name of the agency that has responsibility would be Kentucky Department of Corrections or Kentucky State Police.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does employ full- and/or part-time mental health therapist. The mental health therapist are employees and facility policy requires that they receive PREA training on their responsibilities under the facility's sexual harassment/abuse prevention, detection, and response policies and procedures.

Standard 115.241 Screening for risk of victimization and abusiveness

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

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

Residents are screened during intake for risk of sexual victimization and sexually abusive behavior. The screening instrument contains all 9 criteria to assess residents for risk of sexual victimization and sexually abusive behavior. Documentation of the screening instrument is maintained in each resident file and the facility reassesses the resident's risk of victimization or abusiveness based up on any additional relevant information received by the facility since the intake screening. No resident reported to the auditor that their personal information was used in any exploitative or inappropriate way. The facility policy strictly controls the dissemination of information gathered from the screening.

Standard 115.242 Use of screening information

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

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

Documentation and staff interviews indicate that the facility policy reflects PREA language. The facility does use information from the risk screening required by PREA Standard number 115.241 to decide housing and program assignments with the goal of keeping all residents safe. To date there have been NO transgender or intersex residents admitted to the facility/program but staff have received training for the possibility in future if the need should arise regarding separate shower/housing/and programming assignments.

Standard 115.251 Resident reporting

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation, staff interviews and resident interviews indicate that the facility policy mirrors PREA language. Residents have multiple internal and external ways to privately report sexual harassment/abuse, retaliation by other residents or staff for reporting sexual harassment/abuse, and/or staff neglect or violation of responsibilities that may have contributed to such reports. Staff interviews confirmed that staff can privately report sexual harassment/abuse of resident also. The facility policy is that all staff will accept reports made verbally, in writing, anonymously, and from third parties and promptly document any/all reports.

Standard 115.252 Exhaustion of administrative remedies

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

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

The facility has an administrative procedure for dealing with resident grievances regarding sexual harassment/abuse. Documentation and staff interviews confirm the facility policy is in line with expectations in subsections: the facility does not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual harassment/abuse; the facility does not require a resident to use informal grievance processes with the staff of an alleged incident of sexual abuse; the facility ensures that all residents may submit grievance/grievance processes; the facility allows third parties, including family members, attorneys and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse; the facility policy states that the facility 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. There have been NO submitted grievances regarding an allegation of sexual harassment/abuse to review in the past 12 months.

Standard 115.253 Resident access to outside confidential support services

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

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

The facility currently uses local Bluegrass Rape Crisis Center to provide victim advocate and supportive services to residents upon request. Posters/pamphlets containing contact information are given out during intake process and posted throughout the buildings for resident and staff information/utilization. Resident interviews confirmed that residents are aware of these services and their right to make contact for services. Residents also have access to family members, attorneys, and probation/parole officers.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and interviews confirmed that the facility provides methods to receive third-party reports of resident sexual harassment/abuse and publicly distributes the information on how to report sexual harassment/abuse on behalf of others. PREA pamplets/posters are given to residents during intake/assessment process and posted throughout the buildings for resident and staff information. Residents have access to family members, attorneys, and probation/parole officers.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a)-(e) The facility has policy that requires all staff to report/document immediately any knowledge, suspicion, or information regarding an incident of sexual harassment/sexual abuse that occurred in the facility; to report any retaliation against resident or staff for reporting such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm that when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, the staff have been trained to take immediate action to protect the resident, including but not limited to separating the resident from potential abuser; notifying their supervisor, and completing documentation. All staff expressed that their primary responsibility at all times is the safety of all residents and staff in the facility.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility policy and staff interviews confirm that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Clinical Direcotr/PREA Coordinator must notify the head of the facility/appropriate office at the agency where the sexual abuse is alleged to have occurred and requires notifying the appropriate investigative agency immediately.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility policy and staff interviews confirm that policy does cover all required elements of staff first responder duties/training and staff could articulate the steps they are to take when responding to an incident of sexual abuse.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility's detailed coordinated response plan and staff interviews confirm facility policy/training for actions required in response to an incident of sexual abuse among staff first responders, investigators, and facility leadership.

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

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

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

NOT-APPLICABLE. The facility does not participate in any collective bargaining agreements.

Standard 115.267 Agency protection against retaliation

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

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

The facility documentation and staff interviews confirm agency protection against retaliation and zero-tolerance for retaliation – there have been no reports of incidents of retaliation in the past 12 months.

Standard 115.271 Criminal and administrative agency investigations

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

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

Documentation and staff interviews confirm facility policy is in line with the PREA Standard subsection language. The facility policy requires that all allegations of sexual harassment or sexual abuse be referred for investigation to an agency with the legal authority to conduct criminal investigations (Kentucky State Police) and/or administrative investigations (Kentucky Department of Corrections for probation/parole residents). Investigations are conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports; the credibility of an alleged victim, suspect or

witness would be assessed on an individual basis and shall not be determined by the person's status as resident or staff; investigations include an effort to determine whether staff actions/failures to act contributed to the abuse; documentation is immediate and includes a description of the physical and testimonial evidence, investigative facts and findings; the facility retains all written reports; the departure of the alleged abuser or victim from the employment or control of the facility does not provide a basis for terminating an investigation; the facility cooperates with outside investigators and remains informed about the progress of any investigation until its conclusion/finding and is notified in writing.

Standard 115.272 Evidentiary standard for administrative investigations

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

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

Documentation and staff interviews confirm facility policy is in line with the PREA Standard language. The facility shall impose no standard higher that a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated for administrative investigations.

Standard 115.273 Reporting to residents

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

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

Documentation and staff interviews confirm facility policy is in line with the PREA Standard language, including but not limited to the facility, following an investigation into a resident's allegation of sexual harassment/abuse suffered in the facility, shall inform the resident as to whether the allegation has been determined to be "substantiated, "unsubstantiated", or "unfounded". If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident. All such notifications and/or attempted notifications shall be documented. (f) A facility's obligation to report under this standard shall terminate if the resident is released from the facility'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)

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

Documentation and staff interviews confirm facility policy that staff who violate agency zero tolerance sexual harassment/abuse policies are subject to disciplinary action. Disciplinary actions include but are not limited to a variety of sanctions, including termination. The facility policy requires all allegations of sexual abuse to be reported to the Kentucky State Police, regardless of whether the staff resigns or is terminated.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy that all volunteers, vendors, and contractors are trained/sign an acknowledgment form stating they understand the zero tolerance policy for sexual contact with residents and informed how to report any knowledge, suspicion, or information regarding sexual harassment/abuse that occurred in the facility directly to the Clinical Director/PREA Coordinator. Any volunteer, vendor and/or contractor who were to engage in sexual abuse would be prohibited from contact with residents and reported to law enforcement immediately.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy that all 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 including but not limited to a referral for criminal investigations/possibility of criminal charges. Administrative sanctions are commensurate with the nature and circumstances of the abuse committed; the resident's disciplinary history, whether a resident's mental disabilities and/or mental illness contributed to the behavior; whether or not the resident is on probation/parole (placement could be terminated).

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facilty policy requires that all residents shall have access to unconditional, immediate emergency medical and mental health services.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy requires that all residents shall have access to unconditional ongoing medical and mental heath care for sexual abuse victims (evaluation and treatment shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care (consistent with the community level of care).

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy identifies staff that serve on an Incident Review Team that includes upper-level management staff, with input from therapists, case managers, and others. There have been zero (0) allegations/investigations of sexual harassment/abuse in the past 12 months. The review team would conduct a sexual abuse incident review at the conclusion of every sexual abuse/harassment investigation and would consider including but not limited to the following topics: whether the allegation or investigation indicated a need to change policy or practice to better prevent, detect, or respond to sexual abuse; whether the incident or allegation was motivated by race, ethnicity, gender identity, status or perceived status, or whether it was motivated or otherwise caused by other group

dynamics at the facility. The review team would examine the area were the incident allegedly occurred to assess physical layout; assess the adequacy of staffing levels in that area during different shifts; and assess whether monitoring technology should be deployed. The review team would document its findings in an annual report.

Standard 115.287 Data collection

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

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

Documentation and staff interviews confirmed facility policy requires facility collect accurate, uniform data for every allegation of sexual harassment/abuse at the facility using a standardized instrument and set of definitions provided by the Kentucky Department of Corrections. The facility does maintain, review and collect data as needed from all available incident-based documents and provides monthly reports to the Kentucky Department of Corrections.

Standard 115.288 Data review for corrective action

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

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

Documentation and staff interviews confirmed facility policy to review data collected pursuant to PREA Standard 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training including but not limited to identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings. The facililty report is approved by the agency head.

Standard 115.289 Data storage, publication, and destruction

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

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

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

Documentation and staff interviews confirmed facility policy that ensures data collected pursuant to PREA Standard 115.287 are securely retained. The facility removes all personal identifiers and maintains sexual abuse data collected for at least 10 years after the date of the initial collection.

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Tina Sallee — 8/29/16

Auditor Signature — Date