PREA AUDIT REPORT Interim X Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: November 22, 2016

Auditor Information			
Auditor name: Michelle VanDusen			
Address: 257 Dons Drive, Coldwater, Michigan 49036			
Email: vandusenme@hotmail.com			
Telephone number: 517-414-2375			
Date of facility visit: June 23-24, 2016			
Facility Information			
Facility name: KPEP – Calhoun Facility			
Facility physical address: 203 Brigden Drive, Battle Creek, Michigan 49014			
Facility mailing address: *(if different from above)* Same			
Facility telephone number: 269-963-2085			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	Private for profit
	X Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	X Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Andy Jenie			
Number of staff assigned to the facility in the last 12 months: 9			
Designed facility capacity: 82 Beds			
Current population of facility: 46			
Facility security levels/inmate custody levels: Community Residential			
Age range of the population: 17-63			
Name of PREA Compliance Manager: Andelin Goolsby		**Title:** Accreditation Manager	
Email address: agoolsby@kpep.com		**Telephone number:** 269-903-0532	
Agency Information			
Name of agency: Kalamazoo Probation Enhancement Program (KPEP)			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 519 South Park Street, Kalamazoo, Michigan 49007			
Mailing address: *(if different from above)* Same			
Telephone number: 269-383-0450			
Agency Chief Executive Officer			
Name: William DeBoer		**Title:** Chief Executive Officer	
Email address: wdeboer@kpep.com		**Telephone number:** 269-383-0450	
Agency-Wide PREA Coordinator			
Name: Andelin Goolsby		**Title:** Accreditation Manager	
Email address: agoolsby@kpep.com		**Telephone number:** 269-903-0532	

AUDIT FINDINGS

NARRATIVE

A Prison Rape Elimination Act (PREA) on-site audit (including interviews) of the Kalamazoo Probation Enhancement Program (KPEP)–Calhoun Facility was done on June 23–24, 2016 by Michelle VanDusen, who is a U. S. Department of Justice Certified PREA Auditor for Adult Correctional Facilities. Ms. VanDusen was assisted by Mr. Ray Tamminga who has been trained to become a certified PREA Auditor but is still awaiting final certification. Pre-Audit preparation included a thorough review of all documentation and materials submitted by the facility along with data included in the Pre-Audit Questionnaire. The documentation reviewed included Agency Policies, Procedures, forms, education materials, organizational charts, annual reports, training curriculum, brochures, and other materials that were provided to demonstrate compliance with the PREA standards for Adult Community Confinement Facilities. There was also further discussion via telephone and E-mail between these auditors and Ms. Andelin Goolsby who is the KPEP agency PREA Coordinator about further details and schedules of the upcoming audit.

During the on-site audit, the auditors toured the entire facility accompanied by the Agency PREA Coordinator, spoke with staff and residents, and observed the facility configuration, location of cameras, staff supervision of residents, housing unit layout including shower and toilet areas, placement of posters and PREA informational resources, security monitoring, resident entry and search procedures, and resident programming areas. It was noted that shower and toiletry areas allow for proper residents privacy. Notices of the PREA audit were posted inside the facility as well as at the entranceway.

After the tour, the auditors were provided an office with space to review documents and conduct confidential interviews. The auditors were present at the facility during all three shifts which run from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM and from 11:00 PM to 7:00 AM and observed operations including counts and meals.

Interviews were conducted of seven residents of varying lengths of stay, including one who had screened as potentially vulnerable to sexual assault or sexual aggressiveness or who had reported a previous assault. Another resident declined to be interviewed as he had worked the previous night shift at his job. Another resident self-identified as gay during the interview process. These residents were interviewed utilizing the recommended DOJ protocols that question their knowledge of PREA protections and and their knowledge of reporting mechanisms available to residents to report sexual abuse or harassment. None of the residents interviewed identified any problems or fears of sexual abuse, had some knowledge of PREA protecitions and reporting mechanisms and stated staff were respectful of their privacy and self-announced if they were female before coming into their rooms.

Ten staff persons representing all shifts were interviewed utilizing the DOJ protocols that question their PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges abuse and first responder duties. The following specialty staff questionnaires were utilized during this review:

- Agency Head
- Facility Director
- Agency PREA Coordinator
- Designated Staff Charged with Monitoring Retaliation
- Incident Review Team
- Staff that perform Screening for risk of Vicitimization or Abusiveness (2)
- Intake Staff (2)
- Medical and Mental health staff (2)
- Administrative (Human Resources) Staff
- Staff First Responder (4)
- Random Staff (2)

There have been two allegations of staff sexual misconduct at this facilty in the last two years. Both were determined to be unfounded.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Kalamazoo Probation Enhancement Program (KPEP) is a private non-profit organization providing community residential services to adult male and female offenders in six facilities in four West Michigan counties. The mission of KPEP is, "to operate residential and non-residential programs for adult offenders as a community based alternative to incarceration. We offer the opportunity and structure for men and women to take personal responsibility in their lives." KPEP's service population has historically been adult felony probationers who were placed in either a "Work Release" Program or a regular "Rehabilitative" type of program requiring 90 to 180 days for completion. Recently, KPEP has also been providing programming for the Michigan Department of Corrections (MDOC) parole violators, Residential Substance Abuse treatment (RSA) and re-entry programming including a sex-offender program (RSOP). In addition, three of the KPEP facilities, including KPEP-Calhoun, house Federal Bureau of Prisons and United States Probation Office offenders. Basic core services provided at each KPEP facility include basic GED classes, employability skills training, job seeking, cognitive restructuring classes and substance abuse education.

KPEP-Calhoun is a residential center for adult male offenders located in Calhoun County, a county of approximately 138,000 inhabitants. The building is within the jurisdicition of the City of Battle Creek. The Battle Creek Zoning Board approved the variance request at the current location permitting KPEP to operate a corrections residential center in an area zoned residential. The building itself dates back to 1934. It was constructed during the Depression era as part of the federal WPA program and was a train station. In 1987, Battleridge Limited Partnership purchased the property and entered into an agreement with the Michigan Department of Corrections (MDOC) to remodel the building to accommodate a community corrections center and parole offices. MDOC operated the residential program in the building from 1988 until 1999. The MDOC parole office remained until moving out in early 2005. KPEP commenced operations in the residential section of the building in 1999 and claimed the remainder of the building when the parole office moved out . KPEP purchased the facility in December 2007.

The KPEP-Calhoun Facility is situated on approximately 2 acres of property and consisits of a single story building of brick and cement construction. It is bordered by Brigden Drive on the east and the Battle Creek River on the west. The east half of the building is the residential section and includes the security office, residents rooms, a large multipurpose area, two bathrooms, and a laundry room. Resident capacity is rated at 82 beds and the population count at the time of the audit visit was 43. The administrative section is located in the west half of the building and has offices, classroom space, and storage rooms. Two large classrooms, additional storage areas and the mechanical room are located in the basement. The building was renovated to create more classroom space. The renovation included a new security office and new main entrance to the building.

As a Community Confinement Facility, KPEP-Calhoun is not a "Lock Down" facility. Access to and egress from the facility is controlled and monitored in order to ensure residents remain within the facility and prevent access by the general public. Other than acess to the lobby, all facility entrances are closed and locked from the outside. The security offices are centrally located and accessed by a locked door. Large windows provide observation of the facility and several cameras throughout the facility are monitored from the security office. There are no secure holding areas/rooms and staff will not physically restrain residents to prevent them from leaving the facility. Per their policy, KPEP prohibits the use of force except in instances of justifiable self-defense, protection of residents and others, and prevention of serious loss or damage to property. Residents may not leave the facility without staff permission and then may only travel to authorized destinations in the community. The facility is staffed at all times. Contraband is defined and every resident is searched prior to entering the facility. The nearest Hospital with a full service Emergency Treatment Center where Forensic sexual assault medical exams could be completed is the Bronson Battle Creek Hospital which is less than five miles away.

SUMMARY OF AUDIT FINDINGS

The facility is compliant with all PREA standards except the following two standards:

115.231 Employee Training (a) (2) "How to fulfull their responsibilities under agency sexual abuse and harassment prevention, detection, reporting, and reponse policies and procedures."

Staff were not aware of proper response procedures and policies of incidents of sexual assault or abuse.

115.253 (a), (b), and (c), "Resident access to outside confidential support services"
The Agency has not attempted to enter into a Memorandum of Understanding, nor have they attempted to provide telephone numbers, including toll-free hotline numbers of local advocacy or rape crisis organizations in as confidential a manner as possible. They have also not informed residents of the extent to which such communications will be monitored.

Overall the interviews of residents reflected that they were aware of PREA and somewhat understood the PREA protections and the agencie's zero tolerance policy. Residents received written pamphlets at intake, however they did not receive any contact numbers for agencies nor were there any postings for residents or staff with PREA contact information posted anywhere within the facility.

All facility staff interviewed indicated that they had received training in PREA, however only one staff person could indicate the proper procedures to follow when an incident should occur.

Standards 115.212, 115.234 & 115.266 were found to be Non-Applicable as the agency does not contract with other entities for the confinement of residents, does not conduct its own investigation or train staff to do so, and does not engage in collective bargaining or enter into any collective bargaining agreements.

Corrective Action Taken:

The Agency and Facility have taken further action to ensure compliance with these standards. A Memorandum of Understanding has been entered into with the Sexual Assault Services Program at Bronson Battle Creek Hospital to provide confidential emotional support services related to sexual abuse, provided access to outside victim advocacy services by posting on bulletin boards all necessary information to contact this agency and included this information in orientation training and handouts for all residents entering the program. All staff have been recently trained further in the proper policies and procedures related to incidents of sexual assault and abuse.

Number of standards exceeded: 0

Number of standards met: 36

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)

X 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) 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.
(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.

Compliance Documents:
Agency Policy #2-500.1 Zero Tolerance & Sexual Assault
Agency Policy #6-100.8 Offender Rights (Protection from Sexual Harrassment)
Agency Policy #3-100.4 Rules and Regulations (New Resident Orientation)
Agency Policy #2-500.4 Sexual Assault Control Plan
Agency Policy #2-500.8 Reporting to Residents: Sexual Assault Control Plan
Agency Policy #2-500.9 Medical/Mental Health: Sexual Assault Control Plan
Agency Policy #2-500.10 Review: Sexual Assault Review Plan
Agency Policy #2-500.11 Sexual Assault Control Plan

The KPEP agency has developed policies that meets the requirements of this standard. There is an Agency wide PREA Compliance Manager who told us during her interview, that she has sufficient time to coordinate the facilities efforts to comply with this standard.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(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 contract renewal the entity's obligation to adopt and comply with the PREA standards.

(b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.
(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 Standard does not apply to this facility as KPEP does not contract with other entities for the confinement of residents.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Compliance Documents:
Agency Policy 2-100.4 entitled "Staffing (Adequate Staffing)" requires that "The facility shall be adequately staffed at all times. At least one staff shall be on the premises awake and be able to respond to resident needs twenty-four (24) hours a day."

A Staffing Plan was presented that appeared to provide adequate staffing to protect residents against sexual abuse and sexual harassment. This staffing plan took into consideration the physical layout of the facility, and video monitoring with seven (7) cameras with zoom, pan and tilt capabilities, 2 outdoor and 5 indoors, which all appeared on one color monitor. It had been developed with consideration of observation by staff including video monitoring, as well as protection of the residents through constant circulation throughout the facility. To date, there have been no deviations from the minimum staffing plan. Overtime is authorized, if necessary, to

cover, appropriate staffing positions. This staffing plan is reviewed annually. This information and documentation was presented in interviews with the Human Resources Director, CEO, and Program Manager as well as the PREA Coordinator.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Compliance Documents:
Agency Policy 2-300.2 Contraband (Searches) requires in Section C. 4. a. "Strip searches MUST be conducted by a staff member of the same sex as the resident." Section C. 5. requires that "Staff shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. This information will be obtained from the referral source prior to admission to the program."
Agency Policy 2-300.6 Strip Searches (Procedure) requires that "Only staff of the same sex as the client will participate in the strip search."

The KPEP agency does not allow cross gender strip searches or body cavity searches ever. Female staff members are allowed to conduct pat searches of males but are not authorized to conduct strip searches. This is in their policy and was verified by all staff and residents, and was also observed during our tours. All staff are

trained in proper methods for conducting cross gender pat searches on residents and strip searches if necessary, however, they have not conducted any since the facility has been open. This is also verified in their policy on Contraband (Searches)no. 2-300.2. The training is included in the training curriculum as provided.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.
(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.
(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 effectiveinterpreter could compromise the resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations.

Compliance Documents:
Agency Policy 2-500.3 entitled "Accomodating Special Needs: Sexual Assault Control Plan" requires that KPEP shall ensure that residents with disabilities have an equal opportunity to participate in or benefit from KPEP's efforts to prevent, detect, and respond to sexual abuse and sexual harassment."

KPEP ensures all residents with disabilities have an equal opportunity to participate in or benefit from KPEP's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Residents will not be used as interpreters per their policy 2-500.3 Accommodating Special Needs:Sexual Assault Control Plan. Random interivews revealed their awareness of the contract use for translations services including sign language. In the last 12 months there have not been any requests for the use of an interpreter.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.
(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.
(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.
(d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with residents.
(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.
(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.
(g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.
(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.

Compliance Documents:
7-200.4 Employee Selection, Retention, & Promotions requires in Section F. "KPEP shall not knowingly hire a new employee, promote an existing employee, or 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. Incidents of sexual harassment will also be considered. 2. Has been convicted of, or civilly or administratively adjudicated of engaging in 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. H. All applicants shall be asked about previous misconduct noted in section G above. Omissions regarding such conduct, or the provision of materially false information, shall be grounds for termination. Employees have an on going affirmative duty to disclose any such conduct."
7-200.5 Applicant Background (Investigation) - requires criminal background checks on all applicants for employment.
7-200.6 Performance Evaluations-Requires self-disclosure and states that Omissions "shall be grounds for termination."

The KPEP agency conducts background and other types of criminal and sexual registry checks of new employees, volunteers, and contractors. This is also completed again after five years. They are given yearly evaluations and are required to disclose any such previous misconducts as they relate to this standard and PREA. The Human Resources staff person interviewed confirmed how each employee is screened before hiring and confirmed that if an employee was discovered to have been involved in any criminal activity mentioned in this standard, that employee would be terminated. She also confirmed that checks are completed again after five years.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has not made any additions or modifications to the facility, nor have they added any new video monitoring systems since August 20, 2012. They currently have 7 cameras that monitor specific security areas of the facility and are in the process of purchasing additional cameras that will also be utilized to monitor resident safety from sexual abuse. This was discussed in interviews with Agency Administration staff and the Facility Administrator.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.
(b) The protocol shall be developmentally appropriate for youth 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.
(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 evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.
(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For 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.
(e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.
(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section.
(g) The requirements of paragraphs (a) through (f) of this section shall also apply to:
(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in community confinement facilities; and
(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in community confinement facilities.
(h) For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

Compliance Documents:
Agency Policy 2-500.5 entitled Zero Tolerance & Sexual Assault Control Plan

To the extent the agency is responsible for investigating allegations of sexual abuse, the agency refers individuals to the local hospital and the investigation to the local Law Enforcment Agency, however the facility does initiate the investigation by securing the area where the incident took place, securing all evidence including the physical evidence on the victim and/or perpetrator. The facility sends the victim to the Bronson Hospital, Battle Creek where they are examined by a Sexual Assault Forensic Examiners (SAFE) or Sexual Assault Nurse Examiner (SANE). The victim is referred to the Rape Crisis Center for support. A victim's advocate can be supplied from the Rape Crisis Center upon request from the victim or from the Rape Crisis Center.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.
(b) The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals.
(c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.
(d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations.
(e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations.

Compliance Documents:
Agency Policy #2-500.1 Zero Tolerance & Sexual Assault
Agency Policy #2-500.10 Review: Sexual Assault Review Plan
Agency Policy #2-500.11 Sexual Assault Control Plan

If allegation of sexual abuse occurs, the outside Law Enforcement agency will be referred to for the investigation and determination of an alleged PREA situation. A report will be issued on all determinations of abuse or harassment.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Compliance Documents:
KPEP Training Curriculum
PREA Sexual Abuse: Dynamics, Detection, and Reporting
Agency Policy 2-300.2 Searches
Agency Policy 2-600.1 Security Rounds
Agency Policy 2-100.1 and 2-100.2 Facility Access
Agency Policy 2-100.11 and 2-100.12 Resident Movement/Headcounts/Pass
Agency Policy 2-200.1 through 2.100.3 Use of Force
Agency Policy 2-400.1 to 2-400.3 Key and Tool Control
Agency Policy Sexual Abuse and Sexual Harassment

The facility staff is given access to all the information in which to be trained in the requirements of this standard, however, the way in which the staff are receiving the training appears to be the issue. Of all the facility staff we spoke with, which was seven, only one of the staff could respond to how the process for PREA takes place once staff have received notification that the sexual assault has taken place. This staff person was the Program Manager who is the reporting PREA contact person. All of the other line staff indicated that they would call the Program Manager. Even when given encouragement on the process they were not able to consistently indicate, how to protect the person involved, how to protect/preserve the evidence, where to take the person who has been assaulted, what to do with the person who was the assaulter. The PREA training process needs to be reviewed to determine what is needed for staff to have a clearer knowledge of what to do.

Corrective Action Taken:

All employees who may have contact with residents have recently been trained further on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. This auditor was given copies of training records of all staff, training course outlines, staff meeting agendas, training attendance records, and training handouts explaining these policies

and procedures.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Compliance Documents:
KPEP Training Curriculum
PREA Sexual Abuse: Dynamics, Detection, and Reporting
Agency Policy 7-200.16 Training (Part Time Staff/Volunteers/Interns)
Volunteer/Intern/Contract Staff Orientation Checklist

The orientation training training includes an overview of: agency, code of ethics, client population, services and programs, operational procedures, responsibilities under KPEP's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The Volunteer/Intern/Contract Staff Orientation Checklist includes the following:

Receive Annual Report/mission statement/overview of agency
Review Volunteer/Intern/Contractor Handbook
Give overview of programs, services and client population
Provide description of volunteer position's role, duties and responsibilities
Receive Code of Ethics/discuss expectations and volunteer accountability
Discuss chain of command
Discuss drug/alcohol free work zone
Receive copy of resident handbook
Complete federal volunteer application
Complete LEIN Information Form
Receive rules of confidentiality/sign receipt
Take picture for Volunteer I.D.
Zero Tolerance policy, responsibility and how to report: sexual abuse/sexual harassment reviewed
Tour of the facility.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) During the intake process, residents shall receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.
(b) The agency shall provide refresher information whenever a resident is transferred to a different facility.
(c) The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills.
(d) The agency shall maintain documentation of resident participation in these education sessions.
(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.

During the intake process the residents receive a folder that contains information pertinent to the facility. This folder includes:

Resident Handbook
Intake Checklist
Urine Screening
Instruction and Training Checklist
Health Intake Screening
Health Information along with a Consent to Share form
Basic Information Form
Sexual Assault Awareness Pamphlet

The agency provides information to those residents who may be: deaf, visually impaired, otherwise disabled and limited in their reading skills. The facility maintains files on on residents participation in all informational and educational sessions.

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.

(a) In addition to the general training provided to all employees pursuant to § 115.231, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.
(b) Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.
(c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.
(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.

This standard does not apply to this facility as they refer all investigations to local law enforcement agencies.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:
(1) How to detect and assess signs of sexual abuse and sexual harassment;
(2) How to preserve physical evidence of sexual abuse;
(3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and
(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.
(b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.
(c) The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.
(d) Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.231 or for contractors and volunteers under § 115.232, depending upon the practitioner's status at the agency.

Compliance Documents:
Agency Policy #2-500.1 Zero Tolerance & Sexual Assault

All staff working at the facility are given the PREA Training including the medical and mental health staff. They are trained in how to protect and preserve physical evidence and how to effectively and professionally respond to the victims. However, all forensic examinations are conducted at the Bronson Trauma and Emergency Care Unit or the YWCA Domestic Assault Program.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) All residents shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents.
(b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility.
(c) Such assessments shall be conducted using an objective screening instrument.
(d) The intake screening shall consider, at a minimum, the 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.
(e) The intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive.
(f) Within a set time period, not to exceed 30 days from the resident's arrival at the facility, the facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.
(g) A resident's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.
(h) Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.
(i) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Compliance Documents:
Agency Policy 2-500.4 Sexual Assault Control Plan
Agency Policy #2-500.1 Zero Tolerance & Sexual Assault

All newly admitted residents transferred from another facility are assessed for their risk of being sexually abused by other residents or for them being sexually abusive toward other residents. This is completed within the first 72 hours of their arrival to the facility. The information gathered for risk of sexual victimization includes, previous incarcerations, nonviolent criminal history, prior convictions of sexual offenses against adults

or children, prior sexual abuse acts, prior convictions for violent offenses, and a history of prior institutional violence and sexual abuse. The information gleaned from the assessment is used to notify and determine their housing, their bed, their work assignment, education and program assisgnments. The screening process (COMPAS PREA Profile) considers the following risks of sexual victimization:

Mental, physical or developmental disabilities
Physical build
Age of resident
Perception of gay, lesbian, bisexual, transgender, intersex, or gender nonconforming
Previous sexual victimization
Residents own perception of vulnerability

Within the 30 days of arrival the Counselor reassesses the resident's risk of victimization. Additionally, the resident is reassessed if there is reason to believe: due to referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk factors.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) The agency shall use information from the risk screening required by § 115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.
(b) The agency shall make individualized determinations about how to ensure the safety of each resident.
(c) In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.
(d) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.
(e) Transgender and intersex residents shall be given the opportunity to shower separately from other residents.
(f) The agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents.

Compliance Documents:
Agency Policy 2-500.4 Sexual Assault Control Plan
Agency Policy #2-500.1 Zero Tolerance & Sexual Assault

All residents are screened within the first 72 hours to make classification and placement determinations. If there is a history of victimization, this is reported to the Program Manager. Upon review the Program Manger and/or the Limited License Psychologist

(LLP) may deem a resident unsuitable for placement at KPEP. This also takes into consideration the resident's views as well. Additional measures such as their video monitoring is utilized. The facility is not currently going through any consent decrees, legal settlements, or legal judgement for the purpose of protecting their residents. They have not had any non-consensual, abusive sexual acts, sexual harassment or staff sexual harassment from January 2014 to present.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.
(b) The agency shall also inform residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request.
(c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.
(d) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

Compliance Documents:
Agency Policy 2-500.5 Reporting: Sexual Assault Control Plan
Resident Handbook

At Intake residents are informed of the private multiple ways of reporting sexual assault, sexual harassment and retaliation by other residents or staff. They are advised they may report to their Counselor, Therapist or any other staff person. They are informed they may file through a grievance if that is a preferred way. They are also advised they may report to the local police department or law enforcement agency along with the Bronson Hospital of Battle Creek. Staff will accept reports made verbally, in writing, anonymously, and from third parties. Residents may report privately to the Program Manager, Chief Operating Officer, PREA Coordinator, Director of Treatment Services or other members of the management team.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.
(b)(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
(2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
(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.
(c) The agency shall ensure that—
(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.
(d)(1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance.
(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.
(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.
(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.
(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.

Compliance Documents:
Agency Policy 6-200.3 Discrimination & Grievance
Agency Policy 2-500.5 Reporting: Sexual Assault Control Plan

The facility has a grievance policy that also covers the sexual assault and sexual harassment incidents. The policy outlines the grievance process including time frames. Time frames are not imposed when residents submit a grievance regarding allegations of sexual abuse. All allegations of sexual abuse are immediately forwarded to the Program Manager and processed under the sexual assault control plan. To this date there have been no grievances filed by a resident at the Calhoun facility.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.
(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.
(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.

The facility does have a Community Resource Guide that residents can use to contact local agencies, however they do not have Memorandums of Understanding with any outside victim advocates for emotional support services related to sexual abuse. At this time they have not attempted to gain any Memorandums of Understanding with any potential victim advocates. They do provide the Rape Crisis Centers information should the residents need it. They do receive a pamphlet during intake along with their handbook, however, there are no phone numbers or contacts listed. There are no postings on bulletin boards throughout the facility to give the residents immediate visual information and phone numbers. Residents are advised of the extent to which their phone conversations are monitored and mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosure of sexual abuse made to outside victim advocates, including the limits of confidentiality under federal, state and local laws.

Corrective Action Taken:

The Agency and Facility have recently entered into a Memorandum of Understanding with the Sexual Assault Services Program of the Bronson Battle Creek Hospital for provision of complete confidential emotional support services related to sexual abuse. Information regarding contact information for these services, including the toll-free hotline number and addresses have been posted on bulletin boards throughout the facility. This information has also been included in the resident orientation handouts provided to residents upon entry into the program.

Copies of the MOU, resident pamphlets and handouts, and bulletin board postings including pictures showing them posted, were all given to this auditor confirming their compliance with this standard.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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 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.

KPEP has posted on the Bulletin Board at the front reception area for all visitors, volunteers and residents to see a posting of pertinent information on the factiliy. The last notation on the posting reads:
"KPEP has a zero tolerance policy for sexual abuse and sexual harassment. If you wish to report an alleged incident of sexual abuse or sexual harassment on behalf of a resident click on the resident section at www.kpep.com."

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

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

Compliance Documentation:
Agency policy 2-500.1 section B. 2. requires that "Staff shall immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported such an incident, and staff neglect or violation of responsibilities that may have contributed to an incident or retaliation to the Program Manager…..". Section B. 3. of that same policy requires "Apart from reporting to the Program Manager, staff shall not reveal any information related to a sexual abuse report to anyone other than those designated by the Program Manager." Section B. 4. of that policy requires that "All mental health practitioners are required to report sexual abuseas indicated in section B. 2. above, unless precluded by law. The resident shall be informed at the initiation of services of the practitioner's duty to report." Section B. 5. of that policy requires "If the alleged victim is under the age of 18 or is considered a vulnerable adult, KPEP shall report the allegation to the appropriate State or local services agency under mandatory reporting laws." Section E. 1. of that policy requires that "All instances of alleged sexual assault shall be referred to local authorities for investigation with a recommendation that any resident /staff suspected of sexual assault be prosecuted to the full extent of the law."

The Program Manager of this facilty both stated that all allegations of sexual assault or sexual harassment would be investigated by law enforcement personnel. All staff interviewed were knowledgeable of the requirement to report any and all allegations or suspicions of sexual abuse or harassment to their Program Manager and knew that the local police are the designated investigators for this agency. All staff interviewed were fully knowledgeable of this policy regarding the requirement to report all incidents of this type. The Mental Health Practitioner and the agency Registered Nurse stated their knowledge of the requirement to report any suspicions or incidents of sexual abuse or harassment and stated they also inform each resident when interviewing them of their requirement to report. Staff were also knowledgeable of their requirement to report any third party notices of sexual abuse or harassment when interviewed.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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.

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.

Compliance Documentation:
Agency Policy 2-500.1 entitled Zero Tolerance & Sexual Assault Control Plan, section B. 6. States " Immediate action to protect the resident shall be taken should a resident be at substantial risk of imminent sexual abuse."

Interviews with staff showed institutional knowledge of the requirement that all residents be kept safe from sexual abuse especially if there is any suspicion of imminent abuse. Staff stated they would always find a way to separate the possible victim from any threat of abuse and ensure their safety until such time as they could either move them or the possible assaulter to another room, or another facility depending on the circumstances. Resident Coordinators all stated they would keep any possible victim and assaulter separate until supervisors could determine the best action to take. There have been no incidents of this type reported to date.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Compliance Documentation:
Agency Policy 2-500.5 section H. requires that "Upon receiving an allegation that a resident was sexually abused while confined at another facililty, the Chief Operating Officer shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. Notification will be made as soon as possible, but no later than 72 hours after receiving the allegation. Notification shall be documented. In the event that KPEP is notified by another agency of an allegation that a resident was sexually abused while confined at a KPEP facility, the Chief Operating Officer shall ensure that the allegation is investigated in accordance with policy."

In interviews with the Resident Coordinators and Counselors, they stated they were not aware of any allegations of sexual abuse at another agency but stated they would report such allegations immediately to their supervisor or Program Manager. The Program Manager stated he was aware of this requirement and would notify the other facilty or agency if he heard any allegations of sexual abuse at another facilty or agency but had not heard of any during his time at this facility.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.
(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.

Compliance Documentation:
Agency Policy 2.500.1 section C. 1. requires that staff "Upon learning of an allegation that a resident was sexually abused or if there is reason to believe an assault may have occurred, the first staff member to respond shall do the following: a. Separate the alleged victim and abuser; b. Consistent with KPEP's Preservation of Physical Evidence policy (2-300.3), the staff shall immediately secure the location of the assault and not allow other staff or residents to enter the area. No evidence in the area should be touched or removed pending the arrival of law enforcement personnel. c. With regard to the victim, the following procedures shall be utilized: The victim shall be continually observed and monitored; Staff should respond in a sensitive, supportive and non-judgmental fashion; the victim shall not be allowed to sign-out of the facility; If the abuse occurred within a time period that allows for collection of physical evidence, the victim shall not shower, wash, brush their teeth, eat, drink, urinate, defecate, smoke or change clothing until after they have been initially evaluated by a forensic medical examiner. d. With regards to the perpetrator, the following procedures shall be utilized: Pending arrival of authorities, the perpetrator shall be confined to his/her room and not allowed to sign out. If possible, staff shall not alert the alleged perpetrator of the investigation until after the arrival of the authorities. If the perpetrator is signed-out of the facility when the assault is brought to the attention of staff, authorities shall be notified of the sign-out location in order to make a decision to apprehend the perpetrator at that location or have staff order him/her to return to the facility. Pending the arrival of authorities, staff shall not interrogate or question the perpetrator regarding the assault. Staff shall attempt to maintain the integrity of any evidence by not granting the perpetrator permission to use the toilet or bath facilities, change clothing, eat or drink if the abuse occurred within a time period that allows for collection of physical evidence."

Interviews with staff indicated that all counselors, medical and mental health practitioners and supervisors were fully trained and aware of their responsibilities if a resident reported a sexual assault to them. However, the responses were less consistent when interviewing the Resident Coordinators. Not all RO's stated that they should separate perpetrators or secure the scene and protect the evidence. All of them stated that their first response would be to call the Program Manager and ask what to do. It is this lack of training that is resulting in a finding of non-compliance in standard #115.231 - Employee Training.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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 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.

Compliance Documentation:
As stated above in the response to #115.264 a policy (2.500.1 section C. 1. a - d) is in place to ensure the proper reaction of first responders. This policy goes on futher to state in section C. 1. e. that staff then shall "Immediately contact the Program Manager and take action consistent with the instructions from the Program Manager. This may include moving the victim to a more secure/protective environment, restricting the alleged perpetrator to his/her room and if requested by law enforcement personnel, arrangements shall be made for the victim to go to the area hospital for medical examination and collection of evidence. All victims of sexual abuse shall be referred for forensic medical exams performed by qualified medical examiners (Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE))." In section C. 2. The policy requires that "All victims of sexual assault must be referred to the LLP (Limited License Psychologist). The LLP must meet with the victim within 24 hours of the assault becoming known to staff." The policy goes on to require that all sexual assaults be reported the President/CEO and Chief Operating Officer of the agency and to law enforcement for investigation and require full cooperation.

Interviews with specialized staff confirmed their knowledge of their individual and collaborative responsibilities under this plan and policy. All stated they would report any such incident to their supervisor and Program Manager as well as call the police if any sexual assaults were reported.

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.

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

This standard does not apply to this facility as KPEP does not enter into any Collective Bargaining Agreements with employee organizations or unions.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.
(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.
(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.
(d) In the case of residents, such monitoring shall also include periodic status checks.
(e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.
(f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

Compliance Documentation:
Agency policy 2-500.7 entitled Protection against Retaliation: Sexual Assault Control Plan, spells out the agency goal of protecting all residents who report sexual abuse or harassment from retaliation. It states as follows: "Residents who report sexual abuse or sexual harassment or cooperate with investigations shall be protected from retaliation by other residents or staff." The Procedure reads as follows: "A. The Program Manager shall monitor for signs or reports of retaliation towards residents or staff. B. Protection against retaliation could include; Housing changes or transfers for victims or abusers; Removal of alleged staff or resident abusers from contact with victims; Emotional support services for residents or staff who fear retaliation. C. For at least 90

days following a report of sexual abuse, the Program Manager 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, and act promptly to remedy any instances of retaliation. Monitoring shall include reviewing resident disciplinary reports, progress reports and case notes, periodic resident status checks, a review of housing or program changes, and negative performance reviews or reassignments of staff. Monitoring may extend beyond 90 days as needed. The obligation to monitor shall terminate if the allegation is determined to be unfounded. D. Appropriate measures will be taken to protect any other individual who expresses a fear of retaliation for cooperating in an investigation."

The Program Manager stated during his interview that he was well aware of this responsibility and ensured that staff were well trained to monitor these situations. He responded to questions about possible retaliation with knowledge of the policy and stated he had full flexibility to move both staff and residents to other facilties within their agency if the need arose.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.
(b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.234.
(c) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.
only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.
(e) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.
(f) Administrative investigations:
(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and
(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.
(g) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.
(h) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.
(i) The agency shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

(j) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.
(k) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.
(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.

Compliance Documentation:
Agency Policy 2-500.1, section D. requires that "1. Consistent with KPEP's Critical Incident Policy, any reported incident of sexual assault must be investigated. The nature of such incidents require staff to treat the information gathered in such an investigation in a sensitive and confidential manner. 2. Upon learning of a sexual assault staff will immediately contact the Program Manager, and local law enforcement personnel. The President/CEO and Chief Operating Officer shall be contacted by the Program Manager. 3. The Program Manager will ensure ongoing assistance, cooperation and coordination with authorities, medical/mental health practitioners and probation/parole/BOP agents and shall remain informed about the process of the investigation. 4. Copies of all police reports and other official reports shall be reviewed by the President/CEO the Chief Operating Officer and the Program Manager and included in the critical incident review. A copy of all reports shall be placed in the resident's file. 5. In assaults involving Federal BOP residents, the Program Manager must forward a copy of all investigative reports regarding the assault to the BOP. 6. The departure of the alleged abuser or victim from the employment or control of the facility shall not provide basis for terminating an investigation."

The President/ CEO and the Chief Operating Officer told us in interviews that the agency does not conduct its own investigations. Any investigation of a sexual assault is immediately referred to the local police or sheriff's department. They stated they do everything possible to ensure full cooperation with all trained investigators. The Program Managers stated they were fully aware of this policy and cooperate fully with local law enforcement agencies with any and all investigations. All other staff stated that they knew of the policy to refer any investigations to the local law enforcement and to cooperate fully with any investigations. The local Law enforcement agencies utilize whatever trained investigator is next up in the rotation to investigate any sexual assault or other incidents at the KPEP Calhoun Facility.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

All investigations are completed by local law authorities and then reviewed by the facility staff. They then determine, using the preponderance of evidence as the standard, whether the allegation is determined to be

substantiated or unsubstantiated. This was verified by the PREA Coordinator in conversations and interviews.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.
(b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.
(c) Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:
(1) The staff member is no longer posted within the resident's unit;
(2) The staff member is no longer employed at the facility;
(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.
(d) Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:
(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.
(e) All such notifications or attempted notifications shall be documented.
(f) An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

Compliance Documentation:
The Agency Policy 2-500.8 entitled Reporting to Residents: Sexual Assault Control Plan requires "Following an investigation into a resident's allegation of sexual abuse, the Program Manager shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded." Their Procedure is as follows: "A. KPEP refers all allegations of sexual abuse to law enforcement and shall request the relevant information from the investigative agency in order to inform the resident. B. Following a resident's allegations that a staff member has committeed sexual abuse, the resident shall be informed (unless the allegation is determined to be unfounded) whenever: The staff member is no longer posted at the facility; The staff member is no longer employed by the facility; KPEP learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or KPEP learns the staff member has been convicted on a charge related to sexual abuse within the facility. C. Following a resident's allegation that he or she has been

sexually abused by another resident, the alleged victim will be notified whenever: KPEP learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or KPEP learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. D. All such notifications or attempted notifications shall be documented in case notes. E. KPEP's obligation to report shall terminate if the resident is released from the facility's custody."

Interviews with the Counselors, Mental Health Practitioner, Program Manager and Chief Administrative Officers confirmed that all residents would be kept informed as to the outcome of investigations in compliance with this policy.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.
(b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.
(c) Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.
(d) All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Compliance Documentation:
Agency Policy 2-500.1 section E. Entitled "Prosecution/Discipline" states that "1. All instances of alleged sexual assault shall be referred to local authorities for investigation with a recommendation that any resident/staff suspected of sexual assault be prosecuted to the fullest extent of the law. 2. Any staff involved in sexually abusive or assaultive behavior will be subject to investigation and the KPEP disciplinary process. Staff found guilty of sexual abuse/assault shall be terminated from KPEP. 3. Disciplinary sanctions for staff up to and including termination shall be imposed for the violations of policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse). 4. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for the resignation, shall be reported to law enforcement agencies and to any relevant licensing bodies, unless the activity was clearly not criminal.

The Agency Administrators and the Program Manager stated that they would surely terminate any staff member who engaged in any type of sexual behavior with any resident and that any investigations referred to police agencies would surely be referred with recommendations that anyone found to be engaging in such behavior be fully prosecuted. There appeared to be clear understanding by all interviewed that any behavior of

this type would result in termination of employment, be fully prosecuted and reported to any licensing authority.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.
(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.

Compliance Documentation:
Agency Policy 2-500.1 section E. 8. requires that "Any contractor, volunteer, or intern who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies and relevant licensing bodies, unless the activity was clearly not criminal. Remedial measures will be taken in the case of any other violation of agency sexual abuse or sexual harassment policies, up to and including prohibiting further contact with residents."

The Agency Head/CEO, Agency Chief Operating Officer and PREA Coordinator all stated that these provisions are included in all contracts with their vendors and would be enforced during their interviews. There have been no incidents of sexual abuse or harassment by a contractor or vendor in the past twelve months (or longer).

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.
(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.
(c) The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.
(d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.
(e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.
(f) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.
(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.

Compliance Documentation:
Agency Policy 2-500.1 section E. 5. requires that "Residents involved in sexually abusive or assaultive behavior will be subject to investigation and the KPEP disciplinary procsess. Federal BOP residents shall also be subject to the BOP disciplinary process. Residents found guilty of sexual abuse/assault shall face disciplinary sanctions up to and including termination from KPEP. A resident's mental disability or mental illness contributing to his or her behavior shall be considered when determining a sanction. Residents may also be required to participate in counseling, therapy or other interventions. 6. Residents may only be disciplined for sexual contact with staff upon a finding that the staff member did not consent to such contact. 7. For the purpose of disciplinary action, a report of sexual abuse made in good faith based on a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying."

KPEP has a formal disciplinary process as indicated in the policy and sanctions are issued for sexual assault and/or harassment following this policy.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

(b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, 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.
(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.
(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.

Compliance Documentation:
Agency Policy 2-500.9 requires that "Resident Victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services." The Procedure requires: "A. Staff on duty at the time a report of recent abuse is made shall immediately notify the Program Manager and follow their instructions with regards to contacting the KPEP Limited License Psychologist (LLP) and appropriate medical and mental health practitioners. B. Resident victims of sexual abuse shall be offered information about and access to emergency contraception and sexually transmitted infections prophylaxis as well as pregnancy tests. If pregnancy results, timely and comprehensive information and access to pregnancy related medical services will be given. C. Appropriate referrals and resources shall be available for residents who have been vicitimized by sexual abuse in any prison, jail, lock up, or juvenile facility. Vicitims shall be offered tests for sexually transmitted infections, medical and mental health evaluation and as appropriate, treatment. Evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, referrals for continued care following their transfer to other facilities or discharge from the program. D. Treatment services shall be provided to the victim without any financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident."

There is a local hospital available for treatment of any sexual assault or other emergency medical treatment. It is the Bronson Battle Creek Hospital and it has a Trauma Emergency Treatment Room. It is located less than five miles from the facility and has a fully accredited Full Service Emergency Treatment Center with SANE and SAFE staff on duty at all times. It also offers full service Rape Crisis Treatment, Counseling, and Advocacy services. Residents may access any of these services at any time and they are not charged for these services by the facility. The Rape Crisis Center does not charge any vicitims for their services. Staff may call an ambulance if necessary or provide transportation themselves if necessary and enough staff are on duty. Interviews with the Mental Health Practitioner and the Agency Registered Nurse as well as agency and facility administrators provided information as to the ease of access to these facilties and services.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) 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.

(b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.
(c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.
(d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.
(e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.
(f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.
(g) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.
(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.

Compliance Documentation:
Agency Policy 2.500.9 as quoted in the response to Standard #115.282 above covers this thoroughly in its sections A – D. Section E of that same policy requires that "A mental health evaluation of all known resident-on-resident abusers will attempt to be conducted within 60 days of learning of such abuse history. Treatment shall be offered as deemed appropriate by mental health practitioners."
The Mental Health Practitioner stated that all counseling services are available to any sexual assault vicitim at no cost and arrangements would be made to ensure these services were offered. He also stated that all known sexual abusers are evaluated if possible within 60 days of staff at the agency learning of their history.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.
(b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation.
(c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.
(d) The review team shall:
(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;

(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
(4) Assess the adequacy of staffing levels in that area during different shifts;
(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement, and submit such report to the facility head and PREA compliance manager.
(e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

Compliance Documentation:
Agency Policy 2.500.10 requires that " A sexual abuse incident review shall be conducted at the conclusion of every sexual abuse investigation." The Procedure for this Policy requires that "A. All incidents of sexual abuse shall be reviewed consistent with KPEP's Critical Incident policy. B. Within 30 days of the conclusion of a sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded, a sexual abuse incident review shall occur. The review should include the President/CEO, the Chief Operating Officer, the PREA Coordinator, the Program Manager and any persons as appropriate. Input from investigators, supervisors, medical and mental health practitioners will be reviewed as well. The review will consider: 1. Whether there is a need to change policy or procedure; 2. The motivation for the incident or allegation; 3. The area in which the incident allegedly occurred and barriers in the area that may enable abuse; 4. The adequacy of staffing levels in that area; and 5. An assessment of monitoring technology. C. The review shall be documented in a report and shall include recommendations for improvement. The report shall be submitted to the President/ CEO, the Chief Operating Officer, the Program Manager, and the PREA Coordinator. The Program Manager shall implement recommendations for improvement, or shall document reasons for not doing so."

The PREA Coordinator stated that all incidents of this type are reviewed by a committee and reports issued. There have been very few incidents of this type anywhere in the agency to date but they were all thoroughly reviewed.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.
(b) The agency shall aggregate the incident-based sexual abuse data at least annually.
(c) The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

(d) The agency shall maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.
(e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.
(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.

Compliance Documentation:
Agency Policy 2.500.11 requires that "KPEP shall collect accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions. The date shall be aggregated annually." The Procedure for collection of this data requires that "A. Incident-based data shall include, at a minimum, the data necessary to answer all questions from the Survey of Sexual violence conducted by the United States Department of Justice. Data shall be provided to the Department of Justice upon request. Sexual abuse data collected shall be securely retained and maintained for at least 10 years."

The Chief Operating Oficer and the PREA Coordinator both indicated that they have collected data and have files on the few incidents that have occurred and it is readily available as required.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) The agency shall review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:
(1) Identifying problem areas;
(2) Taking corrective action on an ongoing basis; and
(3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.
(b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.
(c) The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.
(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.

Compliance Documentation:
Agency Policy 2-500.11 Section B. requires that "Data collected and aggregated shall be reviewed and assessed by the PREA Coordinator with the Program Manager of each facility to improve the effectiveness of the sexual abuse prevention, detection, and response policies, practices, and training. This assessment shall include; 1. Identifying problem areas, 2. Taking corrective action on an ongoing basis, 3. A comparison of the current

year's data with those from prior years, 4. An assessment of the facility's progress in addressing sexual abuse. C. A report shall be prepared annually for each facility and KPEP as a whole with its findings and corrective actions and shall be approved by the Chief Operating Officer and President/CEO. Data shall be made available to the public through the KPEP website.

The data from the previous two years was provided to this auditor and is available to the public upon request. The KPEP website directs members of the public to contact the PREA Coordinator if this information is desired.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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) The agency shall ensure that data collected pursuant to § 115.287 are securely retained.
(b) The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means.
(c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.
(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.

Compliance Documentation:
Agency Policy 2.500.11 as documented above for standard #115.288 requires the data to be collected and stored for at least ten years. This auditor reviewed the annual reports for the last two years and found there to be no substantiated incidents of sexual abuse at this facility. This data is available to the public upon request. The KPEP website (www.kpep.com) directs members of the public to contact the PREA Coordinator if this information is desired.

AUDITOR CERTIFICATION
I certify that:

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

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

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

Michelle Van Dusen November 22, 2016

Auditor Signature Date