Prison Rape Elimination Act (PREA) Audit Report
Community Confinement Facilities

☐ **Interim** ☒ **Final**

Date of Report March 20, 2020

Auditor Information

Name: Andy LeClair	**Email:** Andy@lawofficeagl.com
Company Name: Law Office of Andrew G. LeClair	
Mailing Address: 1245 Hancock St., Suite 20	**City, State, Zip:** Quincy, MA 02169
Telephone: 857-400-9398	**Date of Facility Visit:** July 24, 2019

Agency Information

Name of Agency: Centre Inc.		**Governing Authority or Parent Agency** *(If Applicable)*: Click or tap here to enter text.	
Physical Address: 3501 Westrac Drive		**City, State, Zip:** Fargo, ND 58103	
Mailing Address: PO Box 1269		**City, State, Zip:** Fargo, ND 58107	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: http://centreinc.org/prea/			

Agency Chief Executive Officer

Name: Josh Helmer	
Email: joshhe@centreinc.org	**Telephone:** 701-365-4162

Agency-Wide PREA Coordinator

Name: Chris Shotley	
Email: chrissh@centreinc.org	**Telephone:** 701-365-4157
PREA Coordinator Reports to: Josh Helmer	**Number of Compliance Managers who report to the PREA Coordinator:** 3

Facility Information

Name of Facility: Residential Transitional Reentry Center for Women			
Physical Address: 3501 Westrac Drive		**City, State, Zip:** Fargo, ND 58103	
Mailing Address (if different from above): PO Box 1269		**City, State, Zip:** Fargo, ND 58107	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: http://centreinc.org/prea/

Has the facility been accredited within the past 3 years? ☒ Yes ☐ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☒ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☐ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
Click or tap here to enter text.

Facility Director

Name: Vacant – Chris Shotley (acting)			
Email:	Click or tap here to enter text.	**Telephone:**	Click or tap here to enter text.

Facility PREA Compliance Manager

Name: Lindsey Emerson			
Email:	lindseyem@centreinc.org	**Telephone:**	701-365-4177

Facility Health Service Administrator ☒ N/A

Name: Click or tap here to enter text.			
Email:	Click or tap here to enter text.	**Telephone:**	Click or tap here to enter text.

Facility Characteristics	
Designated Facility Capacity:	72
Current Population of Facility:	63
Average daily population for the past 12 months:	47
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☒ Females ☐ Males ☐ Both Females and Males
Age range of population:	19-57
Average length of stay or time under supervision	62 days
Facility security levels/resident custody levels	Non-Secure Residential Reentry
Number of residents admitted to facility during the past 12 months	178
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	169
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	102
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☒ Yes ☐ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☒ Federal Bureau of Prisons ☒ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☒ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☒ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☐ N/A
Number of staff currently employed by the facility who may have contact with residents:	39
Number of staff hired by the facility during the past 12 months who may have contact with residents:	10

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	3
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	1
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	1
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	21
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☐ Yes ☒ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☒ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☒ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	3
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☐ Facility investigators ☒ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☒ N/A

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

Residential Transitional Reentry Center for Women (Westrac) is located in Fargo North Dakota. Westrac is one of four residential reentry centers operated by Centre, Inc. (Community Extended Nuclear Transitional Resident for Ex-Offenders). Agency representatives contacted this auditor to conduct a single auditor audit of their male and female reentry centers located in Fargo North Dakota. The audit was completed by Certified Department of Justice PREA Auditor Andy LeClair. The onsite portion of this audit occurred on July 24-26, 2019. Westrac was previously audited by Dept. of Justice-certified PREA A Dave Andraska, report dated September 7, 2016. Centre, Inc. and this auditor began the contract procurement process for this audit in September of 2018. This auditor has never been employed by, or have received financial compensation outside of payment for this audit, from Centre, Inc. On October 4, 2018, this auditor sent Centre, Inc. a notice that this auditor was on probationary certification status for newly certified Prison Rape Elimination Act (PREA) auditors. On October 15, 2018, this auditor and Centre, Inc. executed a contract for the completion of two PREA audits (123 15th Street and another facility located in Fargo, ND).

Pre-Onsite Audit Phase

The pre-onsite audit phase began with a kick-off conference call between this auditor and the agency's Prison Rape Elimination Act (PREA) Coordinator. This was held on march 21, 2019. During this meeting the following topics were discussed: established primary point of contact; logistics of the field training audit; reviewed the audit process and role of the auditor, purpose, and goals along with expectations; an introduction to the purpose of corrective action; established timelines and milestones for both the pre-onsite and onsite portions of the audit; and discussed the expectation that the auditor will have unimpeded access to facility, documentation, and staff. Following this meeting, this auditor sent a process map to the facility detailing the audit process and expected time allocations while onsite.

On Friday May 10, 2019, notices of the audit were posted in English and Spanish throughout Westrac. The facility exceeded the six-week minimum posting requirement. Audit notices were posted in the kitchen/dining area, in the lounge area, and by the elevator on both the first and second floor, which are located in the lobby. The posting of notices was evidenced by an email from the facility on May 10, 2019 that contained photographs of notices being posted in the above locations. These postings included the auditor's mailing address for staff and residents to mail confidential correspondence to the auditor in advance of the audit. The notices were printed on lime green paper and were posted in both English and Spanish. During the kick-off meeting with the facility, the facility ensured that any mailings to this auditor would be kept confidential. While onsite this auditor met with staff responsible for the collection and distribution of resident mail. This staff person reported that no outgoing mail is screened by the facility

(only incoming). This staff person further informed this auditor that residents typically put any mail directly in the United States Postal Service (USPS) mail boxes outside the facility. The postings were observed while onsite. Prior to the onsite portion of this audit, the auditor did not receive any contacts or correspondence with residents or staff from this facility. During the onsite portion of the audit, this auditor verified during resident and staff interviews that the postings had been displayed since May 10, 2019.

As part of the pre-onsite portion of this audit, the facility completed and uploaded into the Online Audit System (OAS) answers and documentation supporting its position as to compliance into a Pre-Audit Questionnaire. The OAS provides an online interface for Department of Justice-certified PREA auditors and confinement facilities staff in the United States to complete audits on compliance with the Department of Justice's National PREA standards. The facility was asked to upload supporting documentation/content into the OAS by May 1st, 2019. The facility completed this task and notified the auditor on April 29, 2019. The information was uploaded to the OAS for both the male and female facilities (the male facility's audit began July 22nd, 2019). As a result of only one audit being generated in the OAS, the Westrac Final Audit Report was generated utilizing the paper audit instruments. The auditor reviewed the contents of the PAQ, which consisted of: policy, procedures, supporting documentation, and notes from the facility. A comprehensive issue log was developed and reviewed with the facility on July 1, 2019. The issue log is created to identify gaps, missing information, or areas where additional information is needed. The facility provided additional information, as reviewed, on July 19, 2019.

Request for Identification of Residents, Staff and Documents

Prior to conducting the onsite visit to the facility, the auditor requested that the facility identify a comprehensive list of residents, staff, volunteers, and contractors along with relevant facility records to determine the universe of information from which the auditor would sample during the onsite portion of the PREA audit. From these listings, the auditor selected representative samples for interviews (i.e., resident and staff) and document reviews during the onsite portion of the audit. The listings requested by the auditor in the pre-onsite audit phase included:

1. Complete inmate roster (provide based on actual population on the first day of the onsite portion of the audit)
2. Youthful inmates (if any)
3. Inmates with disabilities (i.e., physical disabilities, blind, deaf, hard of hearing, cognitive disabilities)
4. Inmates who are Limited English Proficient (LEP)
5. Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Inmates (identify all inmates in each category)
6. Inmates in segregated housing
7. Inmates who reported sexual abuse
8. Inmates who reported sexual victimization during risk screening
9. Complete staff roster (indicating title, shift, and post assignment)
10. Specialized staff which includes:
    - Agency contract administrator
    - Intermediate- or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment
    - Line staff who supervise youthful inmates, if any
    - Education staff who work with youthful inmates, if any
    - Program staff who work with youthful inmates, if any

- Medical staff
- Mental health staff
- Non-medical staff involved in cross-gender strip or visual searches
- Administrative (human resources) staff
- SAFE and/or SANE staff
- Volunteers who have contact with inmates
- Contractors who have contact with inmates
- Criminal investigative staff (e.g., at agency level, facility level, external entity, etc.)
- Administrative investigative staff (e.g., at agency level, facility level, external entity, etc.)
- Staff who perform screening for risk of victimization and abusiveness
- Staff who supervise inmates in segregated housing
- Staff on the sexual abuse incident review team
- Designated staff member charged with monitoring retaliation
- First responders, security staff (individuals who have responded to an incident of sexual abuse)
- First responders, non-security staff (individuals who have responded to an incident of sexual abuse)
- Intake staff

11. All grievances made in the 12 months preceding the audit
12. All incident reports from the 12 months preceding the audit
13. All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit including:
    - Total number of allegations
    - Number determined to be substantiated, unsubstantiated, or unfounded
    - Number of cases in progress
    - Number of criminal cases investigations
    - Number of administrative case investigations
14. All hotline calls made during the 12 months preceding the audit.

In response to the PAQ (Standard 115.364), the facility indicated that there were no allegations in the twelve months preceding the audit. This auditor was able to review a allegation reported to the Residential Transitional Reentry Center for Males (123 15th Street) to review agency protocols. This allegation was the only allegation forwarded to the agency's investigative body for administrative investigations. The auditor was also made aware that same allegation was referred for criminal investigation. The agency provided the auditor with the administrative and criminal investigative files pertaining to that allegation. While onsite this auditor attempted to identify additional incidents of sexual abuse or sexual harassment during resident and staff interviews. The auditor was not made aware of any additional incidents or allegations.

The auditor contacted the facility's designated local advocate group: Rape and Abuse Crisis Center (RACCFM). RACCFM provides crisis intervention, advocacy, counseling, and prevention education services for those impacted by domestic violence, sexual assault and child sexual abuse. RACCFM provides confidential services to victims at no charge and are available to female and male children, adolescents, adults, and elders. A representative at RACCFM indicated that they have a memorandum of understanding with the agency to provide confidential emotional support services to residents residing at Westrac. RACCFM reported that during the 12-month period preceding the audit, the agency had referred 15 residents for services (from both the male and women's facilities). RACCFM reports that it provides emotional support services to over 3, 000 individuals annually. RACCFM provides services to

any individual that has been impacted by sexual abuse, sexual harassment, domestic violence, child sexual abuse, dating violence, and stalking. RACCFM also has a batterers program that is facilitated on an evening when no victim services are offered. In addition to emotional support services, RACCFM provides the Fargo-Moorhead area with legal advocacy and community education. The auditor also contacted Justice Detention International (JDI). A representative of JDI informed this auditor that JDI had not received any information regarding Westrac.

This auditor was able to make contact with the Emergency and Trauma Department at Sanford Health in Fargo North Dakota. A representative informed this auditor that Sanford Health and Centre Inc. have an existing relationship and Sanford Health would conduct Sexual Assault Nurse Examinations (SANEs) and Sexual Assault Forensic Examinations (SAFEs) for residents of Centre Inc. that report an instance of sexual abuse.

An internet research revealed a number of articles on Centre, Inc., none pertaining to sexual safety. A review of Centre, Inc.'s website – http://centreinc.org/prea/ – revealed the agency has a PREA page that includes the following content: annual PREA reports and assessments, prior PREA audit reports, Sexual Abuse Prevention and Intervention policy, Coordinated Response to PREA Incidents informational, memorandums of understanding with the local police department. North Dakota has a comprehensive mandatory reporting statute, Mandatory Reporting: Abuse and Neglect of a Vulnerable Adult. A review of this statute indicates that all correctional staff are included as mandatory reporters and that the statute covers any intentional or negligent act that causes harm or serious risk to any person older than age 18, or emancipated by marriage that has a substantial mental or functional impairment (2017 N.D. Senate Bill 2322). As of this writing the audit team did not receive any confidential correspondence from residents or staff.

Onsite Audit Phase

The auditor arrived to the Westrac facility on July 24, 2019 to begin the onsite portion of the audit. The final day of the onsite portion of this audit was July 26, 2019. An introduction and security in-brief was conducted with Centre, Inc. administration and leadership, which included: Josh Helmer, Executive Director; Chris Shotley, Director of Operations and PREA Coordinator, and other facility administrators, case management staff, and direct care staff from both locations. During this introduction, the auditor reviewed the onsite PREA audit process, methodology, and other logistical information. This occurred on July 22, 2019. An additional introduction and security in-brief was conducted at Westrac on July 24, 2019 that included: Josh Helmer, Executive Director; Chris Shotley, Director of Operations and PREA Coordinator, finance and human resource representative, facility administrators, case management staff, and direct care staff from Westrac. After the introduction, agency staff members escorted the PREA auditor throughout the facility.

SCYDF is a 72-bed facility with a resident population of 63 on the first day of the onsite portion of the audit. Residents are housed in a single housing unit that has 21 multiple occupancy bedrooms. In the center of the facility is a staff control room where windows span the entire residential component of the facility. The facility has one commercial kitchen that prepares and serves food for residents with an adjoining dining room. Each bedroom has a corkboard/message board, lockers, night stand, and desk. There are two multiple occupant bathrooms on either side of the control room. The facility has one large

outdoor enclosed patio. The second floor of this facility houses agency administrative offices that is separated from the rest of the program by an electronic key card system. On the second floor (prior to the key-carded administrative offices wing) there is also a visitor bathroom and conference room.

The auditor observed daily operations to include: intake/booking process, classification, record storage area, resident education process, grievance system, staff and cross-gender announcements when entering a resident bedroom and housing unit of the opposite gender, and phone systems. This auditor requested that staff demonstrate a mock intake. Staff proceeded by showing this auditor the multi-purpose room that has a large television screen and a desk for two people. Staff put on the PREA video in that room and followed the video with program-specific information. Staff followed by signing onto SecurManage to conduct a risk screening analysis. Staff conclude the mock intake by assigning this auditor a bed assignment and case manager. SecurManage is a web-based software application that tracks and manages aspect of a resident's stay in the facility, including: security and accountability, case management and clinical services, financial obligations and information, employment status, and intake and discharge components. While touring the facility, this auditor observed staff announcing this auditor's presence when entering a key-carded access door to get into the resident's housing unit. This auditor was the only male "staff" that was in the program during the onsite portion of the audit. This auditor was able to test the functioning of the phone system throughout the facility and test reporting lines posted throughout the facility.

While conducting the site review, the auditor reviewed: privacy issues, supervision practices and ratios, programming and education areas, work areas, camera placement and the location of any blind spots, the food service area, storage areas, as well as the basement and roof. This auditor observed no less than two residential specialists present in the facility on each shift (7-3p, 3-11p, & 11-7a). This auditor was able to observe an adaptive-life skills resident group being facility by program staff in the second floor conference room. This auditor was able to locate camera placements throughout the facility and review the and manipulate the display settings at staff computer stations. All areas of the facility were monitored except for certain locations that were restricted by keycard access or hard key access. This auditor observed the roof access and had staff employ key control measures to provide this auditor with access to the roof. During the site review, the auditor conducted informal interviews with residents and staff. The informal interviews covered a wide-range of topics; the overwhelming response and feeling while engaging with residents and staff at the program was that they felt like they resided and worked in a sexually safe environment. PREA-related education materials were observed in the intake/booking area, centrally located at the elevator, and in the dining area. Lastly, this auditor asked a resident if she was willing to demonstrate to me how to file a grievance or submit a written report of an incident. This resident walked me to a rainbow-colored cart that had multiple plastic storage bins. In that cart, there were many different program forms including resident request and grievance forms.

Document Sampling and Review

The facility provided the auditor the requested listings of documents, files and records. From this information, the auditor selected and reviewed a variety of files, records and documents summarized in the following table and discussed in detail below:

Personnel, Training Files, and Background Check Records. The facility has 39 full and part-time staff. The auditor reviewed 11 personnel records that included four individuals hired within the past 12

months as well as seven existing staff members. Additionally, the auditor reviewed one staff who received promotions in the last year. The sample included a variety of job functions and post assignments, including both supervisory and line staff. Files for one volunteer and two contractors who have contact with inmates were sampled randomly across functional service areas. The methodology employed for this audit was selection of the fourth name from the top of a staff roster provided by the facility. The auditor made adjustments to the random sample to reflect a diverse interview pool by selecting the name above the randomly identified selection. Effort was made to corroborate information obtained during staff interviews by reviewing personnel and training files of those staff previously interviewed. Additionally, this auditor reviewed three contractor and volunteer training records.

Resident Files. On the first day of the onsite phase of the audit, the resident population was 62. A total of 13 resident records were reviewed by the auditor. These records included resident education materials, risk screening and processing records, community medical and mental health records. Thirteen resident records were sampled across all housing units in the facility; additionally, the auditor reviewed the records for seven targeted residents that were interviewed. There were no resident files of residents that had reported sexual abuse available for the auditor to review. There were 13 residents available that reported prior sexual victimization. The auditor reviewed the resident file three of these residents (the facility does not employ medical or mental health staff and instead utilizes community-based agencies for these services). The random methodology employed during this audit was a selection of the third resident from the top of a facility provided roster. Additionally, the auditor attempted to corroborate information obtained during resident interviews by reviewing files of those residents that were previously interviewed.

Grievances. In the past year, the facility received 18 grievances; the facility identified that none of those grievances alleged sexual abuse or sexual harassment. The auditor reviewed all 18 grievances.

Incident Reports. The facility reported there were no incident reports alleging sexual harassment and one incident alleging sexual abuse for the 12 months prior to the audit. There was a total of 1,787 incident reports in the last 12 months. The auditor reviewed a random sample of 40 incident reports to corroborate the facility's report.

Investigative files.
The Agency provided the auditor with a list of PREA-related allegations from the previous twelve months. There was one allegation involving staff sexual misconduct that was initially reported as sexual harassment; during the investigation information was provided that the staff may have engaged in a sexual relationship with that client. As a result of this information, the facility referred this matter to the Cass County Sheriff's Department for criminal investigation. The auditor received, reviewed, and retained an investigative file that included the administrative and criminal investigation into a staff-on-resident substantiated allegation of sexual harassment, as well as prosecutorial referral and decision not to prosecute the matter by the agency having jurisdiction. This allegation involved a separate facility.

Interviews: Staff
The auditor conducted interviews with the following agency leadership: Josh Helmer, Executive Director, and Chris Shotley, Director of Operations and PREA Coordinator. The PREA Auditor Handbook (August 2017) specifies "auditors are required to conduct at least 12 interviews with randomly selected staff during the onsite portion of the audit" (*p. 54*). Due to the nature of this agency's allocation of job responsibilities,

some interviewees were asked multiple interview protocols. Additionally, due to the size of the overall staffing pool, all interviewees were asked the random staff protocol. The interviews were conducted in the conference room off of the North Unit's Dining Room. While on the South Unit, the interviews were conducted in the second-floor conference room. These interviews were conducted in private with just the auditor and resident/staff in the room.

The Auditor conducted interviews with the following agency leadership (not counted in totals below):

Mr. Josh Helmer, Agency Head
Mr. Christopher Shotley, PREA Coordinator
Ms. Lindsey Emerson, PREA Compliance Manager

The Auditor conducted the following number of staff interviews during the onsite phase of the audit:

Random Staff (Total) = 12
Specialized Staff* (Total) = 12
Total Staff Interviewed = 12

The breakdown of the specialized staff interviews is as follows:

- Agency contract administrator: (1)
- Intermediate- or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment (1)
- Line staff who supervise youthful inmates (0 – no youthful residents in the facility)
- Education staff who work with youthful inmates (0 – no youthful residents in the facility)
- Program staff who work with youthful inmates (0 – no youthful residents in the facility)
- Medical staff (0 – no medical/mental health staff employed by the agency)
- Mental health staff (0 – no medical/mental health staff employed by the agency)
- Non-Medical staff involved in cross-gender strip or visual searches (1)
- Administrative (human resources) staff (1)
- SAFE and SANE staff (0 – community-based agency interview)
- Volunteers who have contact with inmates (1)
- Contractors who have contact with inmates (0)
- Investigative staff – Criminal investigations (agency level) (0 – agency does not conduct criminal investigations)
- Investigative staff – Administrative investigations (facility level) (1)
- Staff who perform screening for risk of victimization and abusiveness (3)
- Staff who supervise inmates in segregated housing (0 – facility does not have a segregated housing unit)
- Staff on the sexual abuse incident review team (1)
- Designated staff member charged with monitoring retaliation (1)
- First responders, security staff (2)
- First responders, non-security staff (1)
- Intake staff (3)
- Mailroom staff (1)

Total specialized staff interviews* = 18

*__Note__: many of the 18 specialized staff interviewed were responsible for more than one of the specialized staff duties; therefore, the number of specialized staff interviews presented in the table

above exceeds the number of specialized staff interviewed. Additionally, due to the total sample size of available staff (26 full and part-time staff), this auditor interviewed all facility-level staff utilizing the random staff interview protocol in addition to any specialized staff interview protocols.

The random staff were selected across all shifts and housing units. The methodology employed for this audit was selection of one person from each shift during the dates of this auditor's audit. The auditor utilized this methodology as a selection based on the staff roster proved not feasible. The staff roster included part-time/relief staff and staff who were currently out on vacation time, etc. The auditor was given complete discretion to select interviewees independently without input from the facility (excerpt identification of specific staff that performed specialized functions). Random interviews were conducted using the *Interview Guide for a Random Sample of Staff* developed by the Department of Justice. Specialized staff were interviewed utilizing the *Interview Guide for Specialized Staff* developed by the Department of Justice. All staff in this facility perform specialized functions (e.g., Residential Specialists perform risk screening and classification). As a result, all random staff interviewed were additionally interviewed utilizing the specialized protocol that was applicable to their job responsibility.

Interviews: Residents

Based upon the resident population of 62 at the facility on the first day of the onsite portion of the audit, the PREA Auditor Handbook (August 2017) specifies that a minimum of 16 resident interviews must be conducted; a minimum number of eight random resident and eight targeted resident interviews are required.

The auditor conducted the following number of resident interviews during the onsite phase of the audit:

Random Inmates (Total) = 8
Targeted Inmates (Total) = 8
Total Inmates Interviewed = 16

The breakdown of the number of targeted inmate interviews[1] is as follows:

- Youthful Inmates (0 – adult facility)
- Inmates with a Physical Disability (none identified)
- Inmates who are Blind, Deaf, or Hard of Hearing (none identified)
- Inmates who are LEP (none identified)
- Inmates with a Cognitive Disability (none identified)
- Inmates who Identify as Lesbian, Gay, or Bisexual (11 identified – 5 interviewed)
- Inmates who Identify as Transgender or Intersex (none identified)
- Inmates in Segregated Housing for High Risk of Sexual Victimization (none identified; facility does not have a segregated housing unit)
- Inmates Who Reported Sexual Abuse (none identified)
- Inmates Who Reported Sexual Victimization During Risk Screening (13 identified – 3 interviewed)

Total targeted inmate interviews = 8*

*Note: multiple target residents were interviewed using more than one interview protocol as a result of information they provided to the facility at intake or information that they provided to the auditor during their interviews.

The random residents were selected across all housing units. The random methodology employed during this audit was a selection of the third resident from the top of a facility provided roster. The auditor proceeded by selecting the third name down until all interviews were completed. Interviews were conducted using the *Interview Guide for Residents* developed by the Department of Justice.

Targeted residents were identified from listings of residents provided by the facility at the beginning of the onsite portion of the audit. The auditor interviewed all identified residents for this audit. Interviews were conducted using the *Interview Guide for Residents* that includes questions for targeted residents.

Exit Briefing:

An exit meeting was conducted by this auditor at the completion of the onsite portion of this audit. The exit briefing identified areas of strength evidenced by the facility during the onsite portion of this audit and areas that were under focus. The areas of strength discussed were the following: 1) organization and cleanliness of the facility, 2) clear reporting culture exhibited, 3) entrusting staff with expansive roles, 4) the emphasis of a sexually safe housing placement and plan for residents, and 5) the compassionate environment. The areas under focus that were identified were the following: 1) the efficacy and content areas of select trainings, 2) practices around the recruitment, onboarding, and promotion of staff, 3) staff access to sensitive information, 4) accessibility to outside reporting and support services being readily available, and 5) utilization of risk screening for purposes other than housing placement.

Post-Onsite Audit Phase

The auditor submitted an interim audit report to the facility on September 24, 2019. The auditor had numerous follow-up conversations with the PREA Coordinator/Director of Operations, the Facility Director, as well us follow-up conversations with representatives from various community-based partners (to include: the Fargo Police Department and the Rape and Abuse Crisis Center). The Agency provided the auditor with a response and proposed corrective action plan on October 22, 2019. The Agency and auditor formulated a definitive action plan, corrective action milestones, and expected deliverables. Deliverables included: review of updated policy and procedures, re-interviewing staff or collaterals, and review of documentation. Due to existing monitoring and accreditation obligations within the Agency and the varying scope of the corrective action needed, timeframes varied from January 1, 2020 to March 15, 2020. Due to the efforts needed to combat the spread of COVID-19 (“Coronavirus”) and its impact on resources and staff attention during this time, the Agency was given until March 20, 2020 to demonstrate compliance for standards where corrective action was required by March 15, 2020.

Throughout the first quarter if 2020, the Agency provided the Auditor with corrective action deliverables, pursuant to the milestones previously agreed upon. Upon receipt of these deliverables, the auditor verified if these items met the agreed upon corrective action plan and

the applicable provision/standard. Following deliverables, interviews were scheduled on an "as needed" basis. The Agency completed all corrective action milestones and the corrective action plan was closed out on March 19, 2020. The final report was submitted to the Agency on March 20, 2020.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Community Extended Nuclear Transitional Residence for Ex-Offenders (Centre, Inc.) is a private nonprofit corporation with its administrative officed located in Fargo North Dakota. Centre, Inc. was founded in 1976 to provide rehabilitative services to individuals to achieve social reintegration. Centre defines its role as providing for public safety by offering specialized programs in the state that can effectively monitor and house individuals outside of institutions, jails, and prisons. Centre currently has four residential reentry centers in North Dakota: two in Fargo, one in Mandan, and another in Grand Forks. The audited facility is the 3501 Westrac Drive Transitional Residential Reentry Center for Women (Westrac) is located in Fargo North Dakota. The facility is opened in 1987 and maintains contracts with the Federal Bureau of Prisons, U.S. Marshals Service (through its Federal Bureau of Prisons contract), the North Dakota Department of Corrections and Rehabilitation, and the Department of Veteran Affairs. The facility has a capacity of 72 residents.

Westrac reports an average daily population over the last 12 months of 47 residents. On the first day of the onsite portion of this audit, the population was 62 residents. Westrac services residents that are predominantly Caucasian and American Indian. Typically, English is the only spoken language amongst residents and staff, however the facility has had non-English speaking residents, providing language line or other forms of interpreter services. Residents range from the ages of 19 to 57 years-old and, on average, reside at the facility for 62 days.

Westrac reports a total staff size of 39. Westrac employs a total of 16 Residential Specialists, which are its designated security staff. Additionally, the facility has one intern/volunteer and three contractors, three case management staff members, and two high-level supervisory personnel.

Westrac operates in a single newly constructed building comprised a single housing unit for the community confinement of its residents. Westrac is a non-secure residential reentry facility that schedules staff 24/7, the operations of which are video monitored and recorded. The first floor of the facility contains a commercial kitchen, dining room, recreation and seating space, and outdoor patio. The first floor has two multiple-occupant bathrooms that have individual shower stalls that are curtained. The facility has 21 resident bedrooms that house two to four residents; there are no single occupancy rooms or segregated/isolation housing units. Each bedroom has a corkboard/message board, lockers, night

stand, and desk. Additionally, the facility does not have any closed or not in use units within the facility. The facility does not have a medical or mental health unit.

The staff control room is where security staff observe the surveillance cameras, check residents in and out of the program, accept accountability calls, administer medications, and conduct pat/bag searches. Inside the control room a double-locked medication cabinet allows for the distribution of medications during predetermined times. The facility is controlled by a master keycard system as well as a hard key to access secure storage areas, non-utilized areas, and the roof. The hard key must be signed out through the shift supervisor in order to obtain access to these areas.

Centre Inc.'s programming focuses on treating criminogenic and/or destructive behavior and thinking, with services tailored to each individual's needs. The agency strives to ensure its programming continues to evolve and improve with attention given to an expanded array of issues. Cognitive behavioral treatment is a core program component. Addiction programming is mandatory for substance dependent individuals. Vocational counseling, job training, and job placement are priority program objectives for all clients. The staff teaches accountability and personal responsibility to residents/clients within a highly structured program. Consistency of effort and clarity of expectations are the valued underpinning of the case management effort. Each residents program within the context of the larger program is individualized and addresses the individual's issues/risks with a coherent, mutually agreed-upon treatment plan. Residents are referred to and utilize community-based organizations for medical and mental health services.

SUMMARY OF AUDIT FINDINGS (Narrative Form)

The auditor has determined the facility meets all standards for community confinement facilities (41 total standards). Prior to this determination the facility went into a period of corrective action on October 22, 2019 for a total of 14 standards. The timeline for the facility to demonstrate compliance (and complete the corrective action plan) was March 15, 2020. As stated above, the facility was given additional time due to the necessity to mitigate the spread of COVID-19.

The deficiencies initially observed were: the need to have a staffing plan that is the result of an objective analysis of facility, population, and staffing patterns; training on North Dakota mandatory reporting laws and how to professionally and respectfully pat search LGBTI residents; ensuring institutional reference checks are being completed prior to hiring an employing; access to emotional support services for residents classified as "potential abusers"; the use of risk screening results and information for programming purposes other than housing; updating resident disciplinary policies to safeguard good faith reports of sexual abuse or sexual harassment even if they are later unsubstantiated; ensure time standards are tracked during sexual abuse incident reviews; and making sure the annual report has a comparison of the current year's data with those for prior years to assess progress being made.

The Agency took many actions to ensure compliance with the previously identified deficient standards. These efforts included, but are not limited to: expanded existing community partnerships to ensure services are being provided, as required; enhanced and added additional staff training; developed and enhanced policy and procedures; and trained or retrained staff. This auditor and the Agency

established corrective action milestones that spanned the entire first calendar quarter of 2020 (beginning January 1, 2020 and ending March 15, 2020). During this time, the auditor employed various methods to reassess compliance that included: re-interviewing key staff or stakeholders, reviewing enhancements or revisions to policy and procedures and memorandums of understanding with community partners, and reviewing supporting documentation.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: *No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded:

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met:

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.211: Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)

c. Sexual Harassment, Abuse, Assault Policy PE-26 (*effective* 4/12/2019)
d. Centre, Inc. Director of Operations Job Description (*created* 10/18/2013)
e. Centre, Inc. Organizational Chart

2. Interviews
    a. Centre, Inc. PREA Coordinator
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.211(a):

Centre Incorporated (hereafter "Centre") has Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(A) of P-19 establishes "Centre Inc. mandates zero tolerance towards all forms of sexual abuse" (p. 1). P-19 also establishes: "[t]he Sexual Abuse/Assault Prevention and Intervention Policy includes several major elements. These elements include: 1. Prevention. 2. Detection: prompt and effective intervention to address the safety and treatment needs of victims if an assault occurs; and 3. Responding: investigation, discipline, and prosecution of assailants(s)" (p. 2). The Policy elaborates on these three "major elements" throughout the policy: 1) Section I(B)(1)–(2) further establishes expectations around *Prevention*; 2) Section I(B)(a)–(c) provides protocol around the supervision, monitoring, and *Detection*; and 3) Section II(C), (D), & (G) establishes protocols for the reporting, investigation, and prosecution of allegations – *Response*. Additionally, P-19 includes definitions of prohibited behaviors, to include: non-consensual sexual act, abusive sexual contact, staff sexual misconduct, staff sexual harassment, sexual assault, client sexual contact, and client sexual harassment (p. 3–4). Section 8(a) of P-19 establishes that "[s]exual contact between staff and inmates, volunteers, or contract personnel and inmates, regardless of consensual status, is prohibited, and subject to administrative disciplinary and criminal sanctions" (p. 12). Further, Section 8(h) establishes that "[e]mployees, contract volunteers, official visitors, or agency representatives who are found to have committed staff sexual misconduct . . . will face internal discipline, and the facility will also work with laws enforcement to aid in the prosecution of such charges to the fullest extent possible" (p. 12). Section I (B)(2) includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment or residents: "Centre direct-care staff utilizes facility checks/security inspections/resident counts, to maintain resident accountability and safety . . . [o]n-duty direct care staff is expected to be regularly out and about in the resident common areas of the facility . . . [and is] responsible for providing the supervision of residents/clients necessary to protect them from sexual abuse" (p. 3).

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. A review of P-19 reveals that although the policy goes on to outlining the agency's approach to preventing, detecting, and responding to instances of sexual harassment, the policy does not mandate zero tolerance toward all forms of sexual harassment (the policy statement is silent as to conduct other than sexual abuse). Further, the policy references that residents and staff will be disciplined for engaging in relevant prohibited behaviors. However, P-19 fails to include a list of actual sanctions for those found to have participated in prohibited behaviors.

During the post-onsite audit portion of this audit, the Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency reported, "[i]t is Centre Inc.'s understanding that "Sexual Harassment" is a form of "Sexual Abuse" (p. 1). The PREA Coordinator informed this auditor that PE-19 and PE-26 are trained as companion policies. The Agency further provided PE-26: Sexual

Harassment, Abuse, Assault, effective April 12, 2019. Section I provides, "[i]t is a violation to harass any employee, client, or other individual affiliated with Centre, Inc. Any individual determined to have violated this policy will be subject to appropriate disciplinary action, which, I the case of an employee or volunteer, may include termination or dismissal from employment/duty" (p. 76). The policy further provides a definition of Harassment and examples thereof (*See* pp. 77-79).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.211(b):

During the pre-onsite portion of this audit, the Facility acknowledged compliance in this provision in its PAQ response. The facility reported the Director of Operations of Centre, Inc. is the PREA Coordinator and provide the auditor with a job description of that position. The facility also provided the auditor with an organizational chart of the agency. The job description establishes that the Director of Operations is responsible to "[e]nsure the agency adheres to all PREA standards governing community corrections; be aware of applicable PREA updates; update agency policy and procedures accordingly; complete annual report" (p. 2). The agency's organizational chart reveals that the Director of Operation reports directly to the Executive Director who reports to the Board of Directors. The Director of Operations "is responsible for the oversight of . . . operations of all programs for Centre, Inc." (p. 1).

During the onsite portion of this audit, the auditor interviewed the PREA Coordinator. In response to whether they felt that they had enough time to manage all PREA-related responsibilities, the PREA Coordinator responded: "Absolutely, yes. Our team is trained well which allows for delegation of duties making it extremely manageable." The PREA Coordinator reported that during each protocol assessment, he ensures that if any modifications or updates are made, those changes adhere to the PREA standards. Further elaborating that he has a link to the Community Confinement Standards page of the National PREA Resource Center's website as a link on his desktop for direct navigation. In the event that an issue with complying with a PREA standard is identified, the PREA Coordinator reported that he would identify what is causing the non-compliance and develop a corrective action designed to rectify it. He further elaborated that if it was a resource issue, he would explain the issue and need to the Executive Director. Protocol would be assessed to ensure it is designed to be compliant or in need of strengthening. If a policy and procedure update is needed, all applicable personnel would receive retraining. The PREA Coordinator also reported that he would notify our agency's referral source / contract oversight personnel to communicate the issue of non-compliance and our agency's plan to rectify. If needed, he would also consult with the North Dakota Department of Corrections and Rehabilitation's PREA Coordinator for assistance.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

Standard 115.212: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's

obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.212: Contracting with other entities for the confinement of residents.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
2. Interviews
    a. Centre, Inc. Executive Director
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.212(a)–(c):

During the pre-onsite portion of this audit, the Facility on behalf of Centre, Inc. reported in its Pre-Audit Questionnaire (PAQ) responses that they are not a "public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies" (Standard 115.212(a)). The Facility further indicated that the agency has not entered into or renewed a contract for the confinement of residents on or after August 20, 2012 or since its last PREA audit.

During the onsite portion of this audit, this auditor interviewed the Executive Director of Centre, Inc. to review the information provided by the facility in its PAQ responses. The Executive Director corroborated the information provided and informed the auditor that Centre, Inc. does not contract with other facilities to provided services for them and, further, has not entered into any contract for the confinement of its residents since August 20, 2012, which predates their last PREA audit.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

Standard 115.213: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- ☒ Yes ☐ No In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)
  ☒ Yes ☐ No ☐ NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.213: Supervision and monitoring

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Staff Coverage Policy PE-34
    c. PREA Compliant Staffing Plan (*approved* 12/23/2019)
    d. Westrac Female Unit 2019 Staff Schedule (*approved* 1/15/2019)
    e. 3501 Clinical Department Schedule 2019 (*approved* 2/6/2019)
    f. Director of Operations Memorandum, titled: "PREA Assessment/Centre Inc.'s Residential Program located at 3501 Westrac Drive, Fargo, ND 58103"
    g. Engineered Floor Plans indicating camera locations
2. Interviews
    a. Facility Director, or Designee
    b. PREA Coordinator
3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings (By Provision):

115.213(a):

During the pre-onsite portion of this audit, the Facility indicated compliance in this provision in its PAQ responses. The Facility provided this auditor Policy PE-34: Staff Coverage, the Westrac Female Unit 2019 Staff Schedule (approved 1/15/2019), as well as 3501 Clinical Department Schedule 2019 (approved 2/6/2019). The facility further provided the average daily population of 46 since its last PREA Audit in September 2016.

During the on-site portion of this audit, this auditor interviewed the agency PREA Coordinator and the designated individual acting in the capacity as Facility Director. The Facility Director indicated that the facility has a staff plan. The Facility Director reported that the Director of Operations (also PREA Coordinator) conducts an annual assessment of agency wide staffing patterns. Consideration is given to the number of staff on-duty during each particular incident to ensure adequate safety, security and support was provided. If cases exist where the number of staff was not adequate to perform necessary functions, the Director of Operations would increase the number of on-duty staff. Resident occupancy/population trends are also considered. The higher number of residents would equate to assessing the need to increase staffing levels if necessary. If a program was to experience a heightened or non-typical number of substantiated or unsubstantiated sexual abuse incidents, the PREA Coordinator would assess whether or not the deployed number of staff had any impact on the reason for the increase. The Facility Director indicated that video monitoring is part of the plan. The auditor was provided with a copy of the floor plans indicating the location of all video surveillance cameras in (and out of) the facility.

When asked if the staffing plan is documented, the Facility Director responded by informing this auditor that the Director of Operations reviews and approves all Staffing Patterns on an annual basis. Once approved the Director of Operations initials and dates the Staffing Pattern. The Director of Operations maintains all approved Staff Patterns on file. To evidence compliance with this procedure, the facility provided this auditor with the Westrac Female Unit 2019 Staff Schedule (approved 1/15/2019), as well as 3501 Clinical Department Schedule 2019 (approved 2/6/2019). Approval was evidenced by an acknowledgement and signature on a printed copy on the above-mentioned documents.

The Facility Director also indicated that when assessing adequate staffing level and the need for video monitoring, the facility evaluates any blind spots in our video surveillance, the layout of the facility, review past incidents, staff-to-client ratio, and assess if more training is needed. The Facility Director reported that the Facility Manager is responsible to create and post a staff schedule based on the approved Staffing Pattern. On a daily basis, the Program Manager is responsible for ensuring staff arrive and work shifts as assigned.

Also, while onsite, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that when assessing adequate staffing levels and the need for video monitoring, the facility considers: 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) other relevant factors. The PREA coordinator explained he does this by: 1) reviewing the facility's physical layout to ensure as few as possible physical barriers exist that would hinder staff vantage points while considering resident privacy; 2) reviewing surveillance camera locations and their capabilities by conducting a physical walk-through of the campus (the more areas of the facility which are not visible by camera and or have hindered vantage points would be cause to increase staffing levels); 3) reviewing resident utilization and

composition; 4) evaluate the number of staff on shift during substantiated or unsubstantiated sexual abuse incidents; and 5) evaluate the experience and competency of the staff assigned to each shift.

A review of the staffing patterns provided establish that the staffing patterns are master schedules that indicate placement and schedules of staff that have been allocated to the facility. The auditor was not provided a plan that contained a documented objective analysis of what staff and video monitoring are needed to protect the facility population from sexual abuse. "A PREA-compliant staffing plan is a written document that reflects the results of an objective analysis of the facility's staffing needs to ensure sexual safety. The staffing plan must identify the personnel and any video monitoring technology necessary to safely and securely operate a facility in a manner that protects against sexual abuse. The staffing plan must describe the numbers and types of positions and video monitoring equipment needed, and the manner in which they would be deployed within each facility to meet the facility's mission to protect . . . residents from sexual abuse" ("Developing and Implementing A PREA-Compliant Staffing Plan" (p. 4) found at https://www.prearesourcecenter.org/sites/default/files/library/staffingplanfinalwbjalogosubmt.pdf). However, in calculating staffing levels, as required by this standard, the facility has demonstrated that is considers: the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and other related factors.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.213(b):
During the pre-onsite portion of this audit, the Facility indicated that this standard was not applicable. Upon follow-up by this auditor, the facility indicated compliance and reported that there had been no deviations from the plan. The facility did so by providing this auditor with a memorandum titled, "PREA Assessment/Centre Inc.'s Residential Program located at 123 15th St. N. Fargo, ND 58102." In this document, dated January 4, 2019, the Director of Operations indicated, "This assessment found no deviations from the approved staffing plan" over the past 12 months.

During the on-site portion of this audit, this auditor interviewed the designated individual acting in the capacity as Facility Director. The Facility Director indicated that the Program Manager would communicate infidelity to the approved Staffing Plan to the Director of Operations including the reason. This would result in the completion of a Significant Incident Report that would contain all aspects of the issue including the cause and plan for correction as well as chain of command and referral agent notifications. This staff person further explained that Centre has in place an on-call rotation in the event the program cannot find a replacement as a result of sick or vacation coverage.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.213(c):
During the pre-onsite portion of this audit, the Facility indicated compliance in this provision and provided this auditor with a memorandum titled, "PREA Assessment/Centre Inc.'s Residential Program located at 123 15th St. N. Fargo, ND 58102" dated January 4, 2019. This document identified:

> "On this date it was determined that the approved staffing plan for this facility provides adequate levels of staffing and video monitoring to protect

residents against sexual abuse. This assessment found no deviations from the approved staffing plan. The agency has committed the necessary resources to ensure adequate staffing levels.

All relevant factors were taken into consideration including the physical layout of the facility (no remodeling projects have occurred since last assessment), the composition of the resident population and all if any substantiated and unsubstantiated incidents of sexual abuse.

In the past twelve-month period, this facility received (0) allegations."

During the on-site portion of this audit, this auditor interviewed the agency PREA Coordinator. The PREA Coordinator indicated that as the Director of Operations his position is responsible conducting the annual review of the staffing plan.

As established in subsection (a), the facilities provided staffing patterns are not an objective-based PREA-compliant staffing plan. As a result, over the past 12 months, the facility cannot assess, determine, and document whether adjustments are needed to that staffing plan. However, the facility has established a procedure for a review that assesses, determines, and documents whether adjustments are needed to prevailing staffing patterns, to the facility's deployment of video monitoring systems, and whether additional resources are needed to ensure adequate staffing levels.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

1. Develop a Staffing Plan that provides for an objective analysis of what staff and video monitoring are needed to protect the facility population from sexual abuse.
2. Develop a procedure to objectively assess whether adjustments are needed to the staffing plan.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a) and (c) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. The Director of Operations will develop a Staffing Plan that provides for an objective analysis of what staff and video monitoring are needed to protect the facility population from sexual abuse.
2. The Director of Operations will develop and implement a procedure to objectively assess whether adjustments are needed to the staffing plan.
3. The Director of Operations will train all Program Managers and Directors on the newly established Staffing Plan criteria.
4. The Director of Operations will reference the PREA Resource Center's guide titled, "Developing and Implementing A PREA-Compliant Staffing Plan" to ensure the above contains all required elements.

The Auditor's proposed methodology for reassessment was to review the updated Staffing Plan and to conduct a follow-up interview with the PREA Coordinator/Director of Operations. The agreed upon timeline for implementation of the above-referenced actions was January 1, 2020.

On December 23, 2019, the PREA Coordinator/Director of Operations provided the auditor with an updated Staffing Plan Binder for the Facility. The binder is divided into the following categories: Staffing Plan – Written Summary, Facility Diagram, Video Monitoring, Composition of Resident Population, Absenteeism Forecast, Staff Schedule by Shift, Deployed Staff Training, Job Descriptions, Resident Occupancy Percentages, and Prevalence of Substantiated and Unsubstantiated Incidents of Sexual Abuse. A phone interview was conducted with the PREA Coordinator on Monday December 23, 2019 to review the updated Staffing Plan. The PREA Coordinator informed this auditor that the agency utilized the resources provided by the auditor and the PREA Resource Center to create a staffing plan that is the outcome of a thorough and objective assessment of facility needs. The updated Staffing Plan is a documented objective analysis of what staff and video monitoring are needed to protect the facility population from sexual abuse as required by this standard. Further, the Agency provided the auditor with email correspondence between facility and agency managers soliciting feedback and suggestions during its annual review of the new Staffing Plan. As a result of this review the job descriptions for all positions was updated to include "[t]his position is responsible for ensuring and promoting a 'sexually safe' environment." Additionally, job descriptions were updated to include whether the position was a "relieved" or "non-relieved" position (meaning whether or not the position requires replacement staff prior to leaving their assigned post).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.)
  ☒ Yes ☐ No ☐ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) ☒ Yes ☐ No ☐ NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). ☒ Yes ☐ No ☐ NA

115.215 (d)

- Does the facility have policies 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? ☒ Yes ☐ No

- Does the facility have procedures that enables 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? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.215: Limits to cross-gender viewing and searches.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Searches Policy P-18 (*effective* 12/4/2018)
    c. Searches Policy P-18 (*effective* 12/11/2019)
    d. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    e. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 12/11/2019)
    f. Pat-down search Resident Logs (SecurManage)
2. Interviews
    a. Random Staff
    b. Random Residents
    c. PREA Coordinator/Director of Operations
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.215(a):

During the pre-onsite portion of this audit, the Facility indicated compliance in this provision in its PAQ responses and reported the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. The Facility provided this auditor Policy P-18: Searches. Section F of P-18 establishes, "[t]wo or more staff of the same gender as the client must be present to conduct [a strip] search . . . [c]onduct this search away from the view of all other gender staff persons, residents, or visitors" (p. 8). Section G of P-18 further establishes, "[i]f staff suspect's contraband is being hidden in a person's body cavity, they must consult the Executive Director or designee for approval to transport the person to a medical facility to conduct the search" (p. 9). The facility indicated that over the past 12 months, there have not been any cross-gender strip or cross-gender visual body cavity searches of residents.

During the on-site portion of this audit, this auditor was informed that there was no cross-gender strip or cross-gender visual body cavity search logs to review. To corroborate the information provided in the PAQ (that there have been no cross-gender strip or visual body cavity searches conducted), this auditor asked all random residents whether they had been or know of another resident that had been the subject of a strip search or visual body cavity search by a staff person of the opposite gender. Out of 16 residents interviewed, all 16 responded with "they don't do that here" (or similar response). Further, this auditor asked all staff whether these searches were permitted to be conducted. All 12 staff interviewed reported that they were not allowed to conduct these types of searches on a resident of the opposite gender and further informed this auditor that they were not aware of any instance when one was performed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.215(b):
During the pre-onsite portion of this audit, the Facility indicated this provision was not applicable to them as it is a female unit in its PAQ responses. Upon clarification, it was revealed that the provision as applicable as this facility houses female residents. The Facility provided this auditor with Policy P-18: Searches. Section E of P-18 establishes, "[t]wo or more staff of the same gender as the client must be present to conduct [a pat] search. Cross-gender pat down searches of residents is prohibited" (p. 5).

During the onsite portion of this audit, this auditor interviewed 12 staff members and asked them whether residents detained at this facility are restricted from access to programs or outside opportunities in the event a female staff was not available to pat-search them. All staff interviewed reported that this would not happen as there are only female staff employed at this facility. This auditor also conducted 16 randomly selected resident interviews. All 16 residents indicated that they have never been pat-down searched by a male staff and informed this auditor that the only male person that works at the program is the cook and "he doesn't leave the kitchen prep area." All 16 residents confirmed that they had never been restricted from the community for that reason.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.215(c):
During the pre-onsite portion of this audit, the Facility provided this auditor with Policy P-18: Searches and indicated "[n]o cross gender strip searches or cross gender visual body cavity searches." Section F(10) establishes staff shall "[d]ocument all details in a running narrative or Resident Log (SecurManage) in the client's case file" in the event of a strip search (p. 9). Further, G(3) establishes, "[i]f any prohibited material/contraband is found [during a visual body cavity search staff shall] . . . complete a Report of Significant Incident Report" (p. 9). Lastly, Section E establishes that staff shall "[d]ocument all details in a running narrative or Resident Log (SecurManage) in the client's case file" for any pat-down search (p. 7).

During the onsite portion of this audit, this auditor reviewed Resident Logs on SecurManage of six randomly selected residents (of those residents selected by this auditor for interviews). A review of these logs revealed that pat-down searches were conducted by staff of the same gender and all were documented. Additionally, while in the program, this auditor did not observe any male staff in the program or, more specifically, conducting a pat-down search of a resident. As noted above, the facility reported no cross-gender strip, visual body cavity, or pat-down searches being conducted over the past 12 months.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.215(d):
During the pre-onsite portion of this audit, the Facility provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section A establishes, "[i]n non-emergency situations, male employees, interns and volunteers are prohibited from entering female sleeping and bathing quarters if occupied unless they are accompanied by a second staff. Except in the case of emergency or other extraordinary or unforeseen circumstances, Centre Inc. restricts cross-gender viewing by nonmedical staff of residents/clients who are nude or performing bodily functions" (p. 2). Additionally, Section II(B)

defines voyeurism by a staff member, contractor, or volunteer as a prohibited act; defined as: "invasion of privacy of an inmate, detainee, or resident by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals, or breast; or taking images of all or part of an inmate's naked body or of an inmate performing bodily functions" (*see* p. 6). Lastly, Section I establishes, "[s]taff of the opposite gender are required to announce their presence when entering resident sleeping rooms and bathrooms (p. 2).

During the onsite portion of this audit, this auditor interviewed 16 residents and 12 staff. All 16 residents interviewed reported that staff knock and announce their presence prior to entering their bedroom. All 16 residents reported that they had never seen a male staff enter their housing area. The only male individual identified by the residents was the cook but all residents that commented on this staff person said he does not enter the housing unit. The residents reported that the announcement is generally "staff" but that they know the gender based on the sound of the staff's voice. Additionally, all 16 residents reported that they have never been or have seen any other resident be naked in full view of staff, generally, regardless of gender.

This auditor also made observations and engaged informal conversations with residents and staff while conducting the facility tour. This auditor observed all staff announcing their presence when entering a resident's bedroom. Additionally, when on the housing unit, this auditor was accompanied by the PREA Coordinator who is male and by a female staff. Upon entering the housing area (that enters into a television/lounge area) the female staff announced our presence as being males entering the housing unit. The single housing unit has two multiple stall showers that have a two-tier curtain entrance. Residents would enter the first curtain, change, and proceed through the other curtain to shower. When looking inside the bathroom from the staff's vantage point (in the common area), the first stall has a full-length wall that the resident would go around then proceed through the curtain system. From this vantage point this auditor could only see the wall. Additionally, when inside the bathrooms there were no exposed areas. All stalls had curtains for the showers and doors for the toilets. There are no cameras located in resident bedrooms or bathrooms.

12 staff were interviewed comprising only female staff. All 12 reported that they announce their presence when entering a resident's bedroom or when entering the bathroom. Likewise, all 12 staff reported that residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender.

The Department of Justice PREA Working Group defines a housing unit as a "unit [that] contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations" (PREA Auditor Handbook p. 41, *available online at* https://www.prearesourcecenter.org/node/5341). This facility's policies and practice evidenced that staff are aware that if a male staff were to enter the housing unit, they are to announce their presence.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.215(e):
During the pre-onsite portion of this audit, the Facility provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention and indicated compliance in this provision. Section A establishes, "[e]xaminations of transgender individuals to determine their genital status is conducted only by medical practitioners in private settings and only when an individual's genital status is unknown" (p. 2).

During the onsite portion of this audit, this auditor conducted 12 staff interviews. All staff reported that they are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. Two staff referenced the medical exception contained in P-19. The facility reported that there were no transgender or intersex residents residing in the program on the first day of the audit. This audit attempted to verify that by asking staff whether or not they were aware of a current resident in the facility that identified as either transgender or intersex to which this auditor was told there were not any present.

The Department of Justice has issued a Frequently Asked Questions (FAQ) response that is responsive to this practice. "An agency cannot search or physically examine transgender or intersex inmates/residents/detainees for the sole purpose of determining their genital status. As noted in PREA Standards 115.15(d), 115.115(d), 115.215(d), and 115.315(d), if an inmate's, resident's or detainee's genital status is unknown, an agency can determine it through conversations with the inmate/resident/detainee, 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" (December 02, 2016). The examination to identify genital status must be part of a "broader medical examination"; the genital status must not be the sole basis of the examination.

Prior to a period of corrective action, the auditor determined that the agency is not fully compliant with this provision as agency policy allows for the examination of a resident for the sole purpose of determining their genital status.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.215(f):
During the pre-onsite portion of this audit, the Facility indicated that 100% of its staff is trained on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. The facility indicated that the residential staff received training in the "Search policy." Section E of Policy P-18: Searches establishes protocol on how to conduct a pat-down search (p. 5–8). Additionally, it establishes that "[c]ross-gender pat-down searches of residents are prohibited" (p. 5). P-18 is silent on how to conduct searches of transgender or intersex residents.

During the onsite portion of this audit, this auditor interviewed 12 random staff. All 12 staff identified that upon hire and annually, they receive training in P-18 and are required to complete the training titled "Searches and Inspections" on Relias Learning. Additionally, all staff indicated that they had received training on how to conduct pat-down searches of transgender and intersex residents. A review of 16 staff training files revealed that all 16 had completed this training annually.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as staff demonstrated that the training they received includes how to conduct searches of transgender or intersex residents in a professional and respectful manner, consistent with security needs.

Interim Report Corrective Action:

1. Develop or expand existing policy to prohibit physically examining a transgender or intersex resident for the sole purpose of determining their genital status.

Final Audit Report Reassessment:
During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (e) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:
1. The Director of Operations will update P-19 "Sexual Abuse/Assault Prevention and Intervention" and P-18 "Searches" policy and procedure to include prohibiting the practice of physically examining a transgender or intersex resident for the sole purpose of determining their genital status. P-18 "Searches" policy and procedure will be updated to include the requirement of documenting all cross-gender visual body cavity searches.
2. The Director of Operations will communicate this protocol update with all applicable personnel.
The Auditor's proposed methodology for reassessment was to review updated policy and procedures, and review training of applicable personnel. The agreed upon timeline for completing this corrective action was January 1, 2020.

On December 11, 2020, the PREA Coordinator/Director of Operations provided the auditor with a memorandum titled, "Revised policies, procedures, and expected practices." The memorandum delineated a revision to policy P-19: "Sexual Abuse/Assault Prevention and Intervention. The following portion of that policy was deleted from page two: "Examinations of transgender individuals to determine their genital status is conducted only by medical practitioners in private settings and only when an individual's genital status is unknown." Additionally, the following was added in its place: "Centre Inc. prohibits searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status. If a resident's genital status is unknown, staff will communicate with the resident, the referral agency and review documentation provided to Centre from the referral agency to assist with determining the resident's status. It is possible to learn this information as part of a broader medical examination conducted in private by a medical practitioner" (p. 2). An identical passage was added to P-18: "Searches." Additionally, this auditor was provided receipt of service that all staff reviewed this updated policy by January 1, 2020.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.216: Residents with disabilities and residents who are limited English proficient.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
2. Interviews
    a. Agency Head
    b. Residents with disabilities
    c. Resident who are limited English proficient
    d. Random Staff
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.216(a):
During the pre-onsite portion of this audit, the Facility provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention and indicated compliance in this provision. Section II(A)(3) establishes, "[a]ppropriate provisions will be made as necessary for clients with limited English proficiency, clients with disabilities and clients with low literacy levels" (p. 6). Additionally, the facility provided the auditor with a list of North Dakota certified interpreter services that are available in the event one is needed. The list of interpreters includes, but is not limited to: communication services for the deaf, American Sign Language interpreters, voice-to-sign interpreters, and other language-based interpreter services.

During the onsite portion of this audit, this auditor interviewed the Agency Head of Centre Inc – the Executive Director. The Executive Director reported that Centre Inc. has established procedures to provide residents with disabilities and residents who are limited English proficient 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. He further communicated that the Facility's ACA accreditation also mandates we have protocol in place to accommodate translating and providing all program related information including PREA information to residents who may need additional assistance.

On the first day of the onsite portion of this audit, the facility indicated no residents were present in the facility that were classified as having a physical disability; who are blind, deaf, or hard of hearing; who are limited English proficient; or with a cognitive disability. This auditor attempted to corroborate this report during randomly selected interviews and other targeted resident interviews. No residents were interviewed as being classified as having a physical disability; who are blind, deaf, or hard of hearing; who are limited English proficient; or with a cognitive disability.

During the facility tour this auditor observed the list of certified interpreters in the control room. Through informal conversations with staff, it was reported that these services are available and many staff were aware of the male unit employing such services for a resident that was deaf at the facility. In review of the facility characteristics and make up of current population, it was revealed that this facility only occasionally services residents that are limited English proficient. A review of six staff training files revealed that all staff completed "Cognitive-Based Communication Skills with Individual on Community Supervision" on Relias Learning (an online training database); although the target of this training is criminogenic thinking, a review of the training reveals that the recipient will be introduced to four cognitive-based skill strategies that the staff can utilize to improve their interpersonal communication when communicating with residents in their care. Further, all staff identified that they received training upon hire and on an annual basis on the agency's procedures to provide all residents equal access to the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.216(b):
During the pre-onsite portion of this audit, the Facility provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention and indicated compliance in this provision. Section II(A)(3) establishes, "[a]ppropriate provisions will be made as necessary for clients with limited English proficiency, clients with disabilities and clients with low literacy levels" (p. 6). Additionally, the facility provided the auditor with a list of North Dakota certified interpreter services that are available in the event one is needed. The list of interpreters includes, but is not limited to: communication services for the deaf, American Sign Language interpreters, voice-to-sign interpreters, and other language-based interpreter services.

As indicated in provision (a), there were no residents being classified as having a physical disability; who are blind, deaf, or hard of hearing; who are limited English proficient; or with a cognitive disability available for this auditor to interview. However, this facility employs a bilingual staff member that speaks Spanish. Through interviews it was discovered that this staff person on a prior occasion conducted an intake for a limited English proficient resident at the male facility. Prior to this audit, the auditor had occasion to interview this resident. During the course of the abbreviated interview (due to confidentiality) the resident communicated that this staff person made sure he understood all information provided to him at intake, including all PREA-related information communicated during intake and available in the resident handbook.

In review of the facility characteristics and make up of current population, it was revealed that this facility only occasionally services residents that are limited English proficient. When questioned whether the facility has materials available in other languages, the PREA Coordinator (and other staff during informal interviews) communicated that it is very uncommon for a resident to reside at this facility that is limited English proficient.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. The auditor is recommending to the agency a best practice to engage an interpreter services or other professionals hired to ensure effective communication with residents who are limited English proficient in a formal relationship through a memorandum of understanding or contract. This will ensure ease of access and greater overall services to the resident in their care.

115.216(c):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention and indicated compliance in this provision. Section II(A)(3) establishes, “[t]he agency will not rely on resident interpreters, resident readers or other types of resident assistants” (p. 6). The facility indicated that they would document the use of the use of resident interpreters but reported that the facility has not utilized resident interpreters, readers, or any other type of resident assistants over the past twelve months.

During the onsite portion of this audit, this auditor interviewed 12 staff. All 12 staff reported that under no circumstances would the agency ever allow the use of resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. This auditor asked staff a follow-up question as to how would they document the use of resident interpreters, readers, or other type of assistants in the event one was used; the majority of staff informed this writer that they would enter a Resident Log in SecurManage (a secure cloud-based case management software) in that particular resident’s electronic case file.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Recommendations:

1. Engage an interpreter services or other professionals hired to ensure effective communication with residents who are limited English proficient in a formal relationship through a memorandum of understanding or contract.

Standard 115.217: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.217 (c)

- Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal State, and local law: Make its best efforts to contact all prior institutional employers

for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.217 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.217: Hiring and promotion decisions.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Employee Recruitment/Filling a Job Vacancy & Background Check PE-5 (*revised* 8/14/2018)
    c. P-19: Sexual Abuse/Assault Prevention & Intervention (*effective* 1/31/2020).
    d. Meeting Minutes from Agency's Bi-Annual Manager Meeting (November 19, 2019)
    e. Background check records
    f. Personnel files or persons hire or promoted in the past 12 months
    g. Application for Employment
2. Interviews
    a. Administrative/Human Resources Staff
    b. Informal interviews with staff during site review
    c. PREA Coordinator/Director of Operations
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.217(a):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy PE-5: Employee Recruitment/Filling a Job Vacancy & Background Check. PE-5 requires, "[a]ll applicants for employment, internship, or volunteerism with Centre, Inc. are required to provide complete details of a criminal/conviction record or current charges for any violation of the law on Centre's, Inc.'s application" (p. 18). It additionally establishes "[i] the event the prospective employee had previous employment in an institution (jail detention center, prison, or other community corrections or residential facility/program) the manager responsible for hiring will contact all prior institutional employee supervisor for information on whether or not their were any substantiated allegations of sexual abuse" (p. 18). Lastly, the policy establishes "Centre Inc. managerial/supervisory staff carefully considers any history of criminal activity at work or in the community including but not limited to any convictions or adjudications for domestic violence, stalking, and sex offenses. If substantiated, applicants who have engaged in sexual activity in the community facilitated by force, the threat of force, or coercion, will be disqualified from employment with Centre, Inc." (p. 20).

During the onsite portion of this audit, this auditor conducted 12 personnel file reviews selected at random. Of these 12 personnel files, five files revealed institutional reference checks were necessary. Of the 12 personnel files, one individual was promoted within the past 12 months (other files indicated a promotion prior to the last PREA audit). All 12 personnel files (and accompanying criminal record check

binder) contained National Crime Information Center (NCIC) criminal background checks for that employee. Of the five files indicating a need to conduct institutional reference checks, one employee indicated "yes" on the application that they had previously "been employed by an institution (i.e.: prison, jail, community correctional facility, hospital)" (Application for Employment p. 1). Four prospective employees (one being a volunteer) indicated they had "no" prior institutional experience but their work history detailed in pages two and three of their application for employment indicated that they had prior institutional experience as defined by 42 U.S.C. 1997. None of the five personnel files contained the institutional reference check being conducted prior to the employee starting to work. One file contained a situation where one staff person was hired on March 20, 2018 and on April 3, 2018 it was discovered that a resident of a prior residential program alleged that this staff person sexually harassed her. On April 3, 2018, Centre Inc. sent out Request for Information to two institutions on this employee's job application. One prior institution returned information that there was a prior unsubstantiated sexual harassment allegation and another reported that upon investigating a resident allegation that this employee sexually harassed her, this employee "chose to quit instead" of having a meeting.

The one personnel file of an employee being promoted since their last PREA audit did not contain an additional criminal background check, institutional reference check, or administrative adjudication check. Centre Inc. includes the administrative adjudication checks as part of the employee's self-evaluation during a performance review. For this staff person, a self-evaluation was completed on February 27, 2019. However, the staff person was promoted on April 4, 2018. Additionally, there were no NCIC background checks evidenced in this employee's personnel file (either prior to hire or prior to promotion). Centre Inc.'s Application for Employment asks specifically whether the applicant has any convictions or adjudications for domestic violence, stalking, or sex offenses committed in the community.

Agency policy does in fact establish that prospective employees are barred from employment in the event that the individual has engaged in the listed prohibited behaviors. However, an audit of personnel records revealed that this policy is not followed as the agency failed to conduct necessary institutional reference checks on all prospective employees that had prior institutional experience as defined by 42 U.S.C. 1997. Additionally, no background checks were evidenced to be completed for promotions.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.217(b):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy PE-26: Sexual Harassment, Abuse, Assault. Section I establishes, "[i]t is a violation of this policy for ay agent of Centre, employee, volunteer, client, or other individual to harass any employee, client, or other individual affiliated with Centre, Inc. Any individual determined to have violated this policy will be subject to appropriate disciplinary action, which, in the case of an employee or volunteer, may include termination or dismissal from employment/duty" (p. 76).

During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that the Facility considers prior incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. The staff person discussed the above-referenced case where an applicant indicated that they had no prior institutional experience and on-boarding staff did not conduct an institutional reference check based on that applicants work history. Once it was discovered that that applicant had prior institutional experience, it was investigated, and the staff person was terminated as a result of a prior substantiated sexual harassment allegation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.217(c):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy PE-5: Employee Recruitment/Filling a Job Vacancy & Background Check. PE-5 requires, "[a]ll applicants for employment with Centre, Inc. or applicants for internship/volunteerism are required to submit to a criminal background check in accordance with state and/or federal statutes prior to beginning employment or their internship/volunteering" (p. 19). It additionally establishes "[i] the event the prospective employee had previous employment in an institution (jail detention center, prison, or other community corrections or residential facility/program) the manager responsible for hiring will contact all prior institutional employee supervisor for information on whether or not there were any substantiated allegations of sexual abuse" (p. 18). Lastly, the policy establishes "Centre Inc. managerial/supervisory staff carefully considers any history of criminal activity at work or in the community including but not limited to any convictions or adjudications for domestic violence, stalking, and sex offenses. If substantiated, applicants who have engaged in sexual activity in the community facilitated by force, the threat of force, or coercion, will be disqualified from employment with Centre, Inc." (p. 20). The Facility indicated that there were 24 persons hired who may have contact with residents who have criminal background checks over the past 12 months.

During the onsite portion of this audit, this auditor conducted 12 personnel file reviews selected at random. Of these 12 personnel files, five files revealed institutional reference checks were necessary. Of the 12 personnel files, one individual was promoted within the past 12 months (other files indicated a promotion prior to the last PREA audit). All 12 personnel files (and accompanying criminal record check binder) contained National Crime Information Center (NCIC) criminal background checks for that employee. Of the five files indicating a need to conduct institutional reference checks, one employee indicated "yes" on the application that they had previously "been employed by an institution (i.e.: prison, jail, community correctional facility, hospital)" (Application for Employment p. 1). Four prospective employees (one being a volunteer) indicated they had "no" prior institutional experience but their work history detailed in pages two and three of their application for employment indicated that they had prior institutional experience as defined by 42 U.S.C. 1997. None of the five personnel files contained the institutional reference check being conducted prior to the employee starting to work.

During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that the Facility conducts NCIC criminal background checks through the Federal Bureau of Prisons for all newly hired employees who may have contact with residents. This staff person also reported that the facility manager is responsible for sending out the PREA Questionnaire if the applicant indicates they had prior institutional experience.

An audit of personnel records revealed that agency failed to conduct necessary institutional reference checks on all prospective employees that had prior institutional experience as defined by 42 U.S.C. 1997.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.217(d):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy PE-5: Employee Recruitment/Filling a Job Vacancy & Background Check. PE-5 establishes, "[a]ll applicants for employment with Centre, Inc. or applicants for internship/volunteerism are required to submit to a criminal background check in accordance with state and/or federal statutes prior to beginning employment or their internship/volunteering" (p. 19). PE-5 further establishes, "Centre Inc. conducts criminal background records checks at least every five years on current employees and contractors who may have contact with residents" (p. 20). The facility reported that in the past 12 months, there were no contracts for services where those contractors would have contact with resident.

During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that the Facility conducts NCIC criminal background checks through the Federal Bureau of Prisons for all contractors that would have contact with residents. This staff person informed this auditor that there were no contractors currently engaged with the Facility that would have contact with residents. The staff person provided me with orientation packets for the only two contractors that are currently engaged with the facility; an information technology contractor and a printer technician. This staff person informed this auditor that when in the facility, these individuals are accompanied by staff. This was verified throughout the audit during informal conversations with staff that informed this auditor that a staff person always accompanies them during their visit.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. Although the policy does not specifically include contractors as having criminal background checks being conducted before enlisting the services of that contractor, procedures are in place to ensure background checks of contractors who may have contact with residents are completed.

115.217(e):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy PE-5: Employee Recruitment/Filling a Job Vacancy & Background Check. PE-5 establishes, "Centre Inc. conducts criminal background checks at least every five years on current employees and contractors who may have contact with residents" (p. 20).

During the onsite portion of this audit, this auditor conducted 12 personnel file reviews selected at random. Of these 12 personnel files, four files were audited of employees that had been employed for longer than five years. All four files contained NCIC criminal background checks ran by the Federal Bureau of Prisons every five years. Further, this auditor was provided access to this Facility's criminal background check binder that contained all criminal background checks for active employees. A spot check of additional staff revealed that criminal background checks are ran every five years. During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that the Facility utilizes the Federal Bureau of Prisons to conduct all of their criminal background records check and that is done upon hire and every five years for all current employees and contractors who may have contact with residents.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.217(f):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with a copy of its Application for Employment. Centre Inc.'s Application for Employment specifically asks whether the applicant has any convictions or adjudications for domestic violence, stalking, or sex offenses committed in the community in three separately delineated questions.

During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that the Agency asks all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this standard. This person reported that this is done prior to hire on the Application for Employment and on an ongoing basis on the staff person's self-evaluation form that is completed annually as part of their performance review. Additionally, this staff person reported that on the first day or orientation, the new employee is provided an employee handbook and this staff persons reviews that all employees have an affirmative duty to continue to disclose any such misconduct.

During the onsite portion of this audit, this auditor conducted 12 personnel file reviews selected at random. Of these 12 personnel files, five files were audited of employees that had received and were eligible for a performance review. All five reviews included a self-evaluation form that asked employees about previous misconduct (same questions as were on the Application for Employment).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.217(g):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy PE-5: Employee Recruitment/Filling a Job Vacancy & Background Check. PE-5 establishes, "[f]alsifying any information on an application will be grounds for not hiring and or other disciplinary action up to and including termination" (p. 18).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as Agency has a policy responsive to this provision.

115.217(h):
During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that this position would be the position responsible for providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee. This staff person reported that the Agency would comply with another institution's request for information. This staff person was not aware of any North Dakota law that would prevent the Agency from doing so.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as Agency has a policy responsive to this provision.

Interim Report Corrective Action:

1. Establish or improve procedures that ensures that the agency will 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 has engaged in the prohibited behaviors.
2. Establish and implement procedures that ensures that the agency makes 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.

Final Audit Report Reassessment:
During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a) and (c) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. The Director of Operations will enhance existing Policy and Procedures (Employee Recruitment/Filling a Job Vacancy & Background Check & Sexual Abuse/Assault Prevention & Intervention) to ensure that the agency will 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 has engaged in the prohibited behaviors. This will include a procedure that ensures the agency makes 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.
2. The Director of Operations and Human Resources Generalist will provide in-person training to all hiring managers on the procedure for contacting all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse, prior to beginning employment, interning, or volunteering at Centre.

The Auditor's proposed methodology for reassessment was to review policy and procedure updates and/or enhancements, review hire promotion files (if available), and conduct a follow-up interview with the PREA Coordinator/Director of Operations. The agreed upon timeline for implementation of the policy enhancements as outlined above was March 15, 2020 and to conduct the in-person training was January 1, 2020.

On January 22, 2020, the PREA Coordinator/Director of Operations provided the auditor with an attendee list and meeting minutes for the Agency's Bi-Annual Manager Meeting that occurred on November 19, 2019. The minutes included the topic of conducting institutional reference checks for all new hires, volunteers, and promotions, facilitated by the Executive Director and Human Resources Generalist. Additionally, the Agency provided the auditor with updated Request of Information and Release of Information forms for prospective new hires and promotions, effective 12/2/2019. Additionally, on January 31, 2020, the Agency provided the auditor with a policy updated to P-19: Sexual Abuse/Assault Prevention & Intervention (*effective* 1/31/2020). P-19 was revised to include the following in its policy statement:
"Centre Inc. personnel adhere to PREA standard 115.217 Hiring and Promotion Decisions. In the event the prospective employee had previous employment in an institution, hiring managers must make their best efforts to contact all prior institutional employers. "Institution" includes the following but is not limited to: Jail, Detention Center, Prison, Law Enforcement, Human Service Organization, Nursing Home, Community Corrections, Residential Care Facility, [and] Daycare. During their initial contact with prior institutional employers, the hiring manager is responsible for obtaining information on whether or not there were any substantiated allegations of sexual abuse against the prospective employee. Centre Inc. prohibits the hiring or promotion of anyone who is found to have contact with residents and have engaged in sexual abuse in an institution, have been convicted of attempting or engaging in a nonconsensual sexual activity in the community, or have been civilly or administratively adjudicated in nonconsensual sexual activity. Similarly, Centre Inc. prohibits the enlistment of services of any contractor who may have engaged in sexual abuse in an institution, have been convicted of attempting or engaging in nonconsensual sexual activity in the community, or have been civilly or administratively adjudicated in nonconsensual sexual activity" (p. 2).

A phone interview was conducted with the PREA Coordinator on Friday February 7, 2020 to review the updated policy and procedure. The PREA Coordinator informed this auditor that there had not been any promotions to review nor had there been any new hires needing institutional reference checks since the

corrective action plan was put in place but that this area is something the Agency is paying close attention to.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.218: Upgrades to facilities and technology.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Facility Site Plans
2. Interviews
    a. Agency Head
    b. Facility Director of Designee
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.218(a):

During the pre-onsite portion of this audit, the Facility indicted that Agency/Facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit, completed on September 7, 2016.

During the onsite portion of this audit, this auditor interviewed the Agency Head (Executive Director of Centre, Inc.) as well as the person designated as the Facility Director (position was vacant at the time of the onsite portion of this audit). The Executive Director reported that although no new substantial expansions or modifications have been completed since the last PREA audit, in the past, when Centre has planned projects, the initial meeting with the architects involves a discussion about the importance of site lines for staff to ensure the sexual safety (and general safety) of the residents in their care. Additionally, the Executive Director reported that Centre Inc. has PREA in mind whenever they update or design the camera surveillance, door lock, and card access systems. The Facility Director reported to this auditor that no major renovations were done to the facility nor has any changes been made to the facility's video surveillance system since the last PREA audit. The PREA Coordinator provided this auditor with facility plans listing surveillance camera locations with their respective angle of observation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the agency considers the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse.

115.218(b):

During the pre-onsite portion of this audit, the Facility indicted that there have been changes or additions to their video surveillance system since the last PREA audit, completed on September 7, 2016.

During the onsite portion of this audit, this auditor interviewed the Agency Head (Executive Director of Centre, Inc.) as well as the person designated as the Facility Director (position was vacant at the time of the onsite portion of this audit). The Executive Director reported that Centre Inc. has a newly installed camera surveillance system that was installed in 2017. The Executive Director reported that the upgraded system was selected because it was modern, had better picture quality, and is easily accessible from any employee's computer. All these, it was reported, were aimed at providing a safer environment for the residents in their care. The Executive Director also reported that they have added cameras to enhance coverage of all common areas in the facility. The Facility Director reported that when installing or updating monitoring technology, such as a video monitoring system or electronic surveillance, the facility considers the effect of the facilities design and account for any blind spots in observation to enhance residents' protection from sexual abuse.

During informal conversations with staff, including the PREA Coordinator, Executive Director, and direct care staff, all reported that when speaking of safety and security, PREA and promoting a sexually safe environment free of sexual abuse is at the forefront of every conversation whether its during supervision or during staff meetings.

Additionally, during the site review, this auditor sat down with his escorting staff person to review the video surveillance system. The system has a total of 20 cameras. All cameras were operational. The system is accessible from any computer on the network. The cameras can be seen in various groupings and in varying sizes of display. The picture quality is clear. Staff stations have two screens – one to operate SecurManage and accountability tracking and another that has the surveillance system on screen at all times. This was reviewed and verified throughout the site review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the agency considers how the installation of or upgrading of its video monitoring system may enhance the agency's ability to protect residents from sexual abuse.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☒ NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination

issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.221: Evidence protocol and forensic medical examinations.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Memorandum of Understanding between Centre, Inc. and Fargo Police Department
    d. Memorandum of Understanding between Centre, Inc. and Rape and Abuse Crisis Center
    e. Centre Inc. Coordinated Responses to PREA Incidents
    f. Office of the Attorney General's North Dakota Sexual Assault Evidence Collection Protocol
    g. Office of the Attorney General's Guidelines for Packaging and Submission of Evidence
2. Interviews
    a. Random Staff
    b. PREA Coordinator
    c. SAFE/SANE Community-based Provider
    d. Rape and Abuse Crisis Center
    e. Residents who Reported a Sexual Abuse
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):
115.221(a):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. The facility indicated in the PAQ that the agency/facility is responsible for conducting administrative sexual abuse investigations. However, P-19 establishes that they do not conduct administrative investigations of allegations of sexual abuse. Section I(D)(4)(b)(3) establishes that in the event there is a report of a recent non-consensual act (occurring within 72 hours), staff are to engage first responder duties and "[n]otify the local law enforcement agency having jurisdiction of the allegations and confirm [their] plan for investigation including time line(s)" (p. 9). Additionally, Section I(D)(5)(a)(4) establishes that in the event there is a report of non-consensual acts occurring 72 hours or more in the past, staff are to engage first responder duties and "[n]otify the local law enforcement agency having jurisdiction of the alleged incident and request they begin the investigation" (p. 10). Lastly, in the event there is a report of abusive sexual contacts, [i]f after the initial interview with the victim, the victim would like to file a police report and/or if the staff person suspects a crime may have been committed, the staff person will notify the local law enforcement agency having jurisdiction and request that they take over the investigation" (p. 11). The facility reported that the Fargo Police Department is the agency that has responsibility for conducting sexual abuse investigations.

During the onsite portion of this audit, this auditor interviewed the agency investigator to review whether the agency conducts administrative investigations of sexual abuse. The agency investigator informed this auditor that in the event of an allegation of sexual abuse, the Fargo Police Department would be responsible for conducting the investigation. Responding staff would be responsible for securing the scene and prevent the destruction of any evidence (among other duties) until police can arrive. This auditor interviewed 12 random staff. All staff reported that the agency's investigator is the PREA Coordinator; in addition, all staff indicated that if they received a report of a sexual assault they were to keep the alleged victim safe, secure the scene and protect against any destruction of evidence, call the on-call and PREA Coordinator, and immediately contact local law enforcement in order for them to begin their investigation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not responsible for conducting any form of criminal or administrative sexual abuse investigations and this provision is, therefore, not applicable.

115.221(b):
The agency is not responsible for conducting any form of criminal or administrative sexual abuse investigations and this provision is, therefore, not applicable. During the pre-onsite portion of this audit, the facility provided this auditor with a Memorandum of Understanding with the Fargo Police Department that established, the Fargo Police Department "[u]tilize[s] protocol based on the 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."

115.221(c):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(A) establishes, "Centre Inc. will refer all victims (client/offender-on-client/offender or staff-on-client/offender) of sexually abusive penetration to a qualified forensic medical examiner. All forensic medical exams will be provided

free of charge to the victim. Centre Inc. will make available or provide by referral a victim advocate to accompany the victim through the forensic medical exam process" (p. 2). The facility also provided this auditor with Centre Inc.'s "Coordinated Response to PREA Incidents." The flow chart provides that staff shall "[e[ncourage SANE exam if warranted." The facility reported that there have been no forensic medical examination conducted.

During the onsite portion of this audit, this auditor observed the "Coordinated Response to PREA Incidents" displayed on the wall at the control room of both Units. This auditor also spoke with an executive-level representative at Stanford Health in Fargo, ND. This representative informed this auditor that Sanford Health and Centre Inc. have an ongoing professional relationship and that the Emergency and Trauma Department at Sanford Health in Fargo North Dakota employs SANEs/SAFEs that would conduct forensic examinations for the residents of Centre. This auditor also spoke with an executive level representative of the Rape and Abuse Crisis Center located in Fargo North Dakota. This representative informed this auditor that the Rape and Abuse Crisis Center would provide complimentary transportation from the facility to Sanford Health for the completion of forensic medical examinations.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.221(d):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with a Memorandum of Understanding between Centre, Inc. and Rape and Abuse Crisis Center in Fargo North Dakota. The MOU stablishes that the Rape and Abuse Crisis Center will provide the facility with "confidential emotional support services related to sexual abuse." During the post-onsite portion of this audit, this MOU was updated to include, "The Rape and Abuse Crisis Center of Fargo, ND provides qualified agency staff members who have been screened for appropriateness to serve in their respective role(s) and have received education concerning sexual assault and forensic examination issues in general. Where necessary, the Rape and Abuse Center 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. Any Centre Inc. Residential client may discreetly contact Rape and Abuse Crisis Center directly." This update was evidence by providing this auditor with an executed MOU between both parties signed into effect on September 5, 2019.

During the onsite portion of this audit, this auditor interviewed the agency's PREA Coordinator and an executive-level representative of the Rape and Abuse Crisis Center. The PREA Coordinator reported, Centre Inc. has a MOU with local Rape Abuse Crisis Centers. Typically, the assigned Case Manager would facilitate and assist the client with accessing these services. Centre Inc. validates the service provider's credentials through either requesting documentation from them or obtaining it via the company website. Centre Inc. has entered into formal MOUs with the service provider outlining Standard 115.221's expectations. A representative from the Rape and Abuse Crisis Center reported that the two agencies have been in a formal agreement for at least the past six years (this person's entire tenure at the Rape and Abuse Crisis Center). This representative reported that the Center is available for victim advocate services 24 hours a day, seven days a week and will make staff available for residents of Centre, Inc.

On the first day of the onsite portion of this audit, the facility indicated no residents were present in the facility that were classified as reporting a sexual abuse. The auditor attempted to corroborate this report during interviews with randomly selected residents. No residents were identified as having reporting a sexual abuse.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.221(e):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(A) establishes, "Centre Inc. will make available or provide by referral a victim advocate to accompany the victim through the forensic medical exam process" (p. 2).

During the onsite portion of this audit, this auditor interviewed the agency's PREA Coordinator. The PREA Coordinator reported that if requested by the victim, a qualified community-based advocate from the Rape and Abuse Crisis Center would accompany and provide emotional support services, crisis intervention, information, and referrals during the forensic examination process and investigatory interviews. As noted in subsection (d) of this standard, there were no residents present in the facility during the onsite portion of this audit that reported sexual abuse.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.221(f):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with a Memorandum of Understanding between Centre, Inc. and the Fargo Police Department. The MOU establishes that the Fargo Police Department "[u]tilize[s] protocol based on the 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." A review of the State of North Dakota's Office of Attorney General "Guidelines for Packaging and Submission of Evidence," establishes that law enforcement agencies are to follow uniform collection practices for the packaging of DNA/Biological Evidence, among other classifications of evidence (*see* p. 3). Additionally, the Office of Attorney General supports local law enforcement agencies by distributing the "North Dakota Sexual Assault Evidence Collection Protocol" for use in investigating crimes of sexual assault. This protocol includes guidance for local law enforcement agencies for the utilization of SANEs. Additionally, it establishes that "[i]t is highly important that an advocate or support person be available to each sexual assault victim, regardless of age. Whenever possible, one support person should be assigned to stay with the victim during any interviews, as well as the entire visit to the emergency department" (p. 31).

During the onsite portion of this audit, as noted in subsection (f), despite this agency not being responsible for conducting criminal and administrative sexual abuse investigations, it ensures that the victim is accompanied by a qualified community-based victim advocate through the forensic examination process and investigatory interviews through a MOU with the Rape and Abuse Crisis Center.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. The facility has entered into a MOU with the Fargo Police Department for the completion of sexual abuse investigations. The facility ensures that the investigating agency follow the requirements of paragraphs (a) through (e) in that the Fargo Police: (a) follows uniform evidence protocols; (b) ensures the protocol was adapted from the DOJ'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) ensures forensic examinations are conducted by SANEs/SAFEs; (d) the victim advocates are made available to the victim; and (e) when requested, a victim advocate accompanies and supports the victim through the forensic examination process and investigatory interviews.

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

115.221(h):
During the post-onsite portion of this audit, this MOU was updated to include, "The Rape and Abuse Crisis Center of Fargo, ND provides qualified agency staff members who have been screened for appropriateness to serve in their respective role(s) and have received education concerning sexual assault and forensic examination issues in general." This update was evidence by providing this auditor with an executed MOU between both parties signed into effect on September 5, 2019.

During the onsite portion of this audit, this auditor interviewed an executive-level representative of the Rape and Abuse Crisis Center. The representative from the Rape and Abuse Crisis Center reported that the Rape and Abuse Crisis Center is a nationally-recognized victim services agency and prides itself on employing only qualified victim service advocates.

Based upon the review and analysis of all the available evidence, the auditor has determined that this provision is not applicable to the agency as the agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to

conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.222: Policies to ensure referrals of allegations for investigations
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 1/31/2020)
    d. Memorandum of Understanding between Centre Inc. and Fargo Police Department (effective 1/29/2020)

e. Agency Website: http://centreinc.org/wp-content/uploads/2018/11/Sexual-Abuse-Assault-Prevention-and-Intervention-2018.pdf
f. Criminal and Administrative Investigative Files

2. Interviews
    a. Centre, Inc. Executive Director
    b. Investigative Staff
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.222(a):

Centre Incorporated (hereafter "Centre") has Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section II(D) of P-19 establishes the protocols for "Investigations of Non-Consensual Sexual Acts, Abusive Sexual Contacts, Client Sexual Harassment, Staff Sexual Misconduct, or Staff Sexual Harassment" (*p.* 8). Centre has documented procedures establishing that all allegations of sexual abuse and sexual harassment, as delineated above, are investigated (*p.* 8–13).

During the pre-onsite portion of this audit, Centre, Inc. indicated that over the past 12 months, there had been one allegation of sexual harassment occurring at another facility. The Agency reported that this allegation resulted in the completion of an administrative investigation. The agency investigator substantiated the sexual harassment allegation at the completion of his administrative investigation. As a result of the administrative investigation, the alleged staff member "[h]as been included as a suspect in [a criminal] case, which was presented for prosecution to local authorities" (p. 1). The administrative investigation yielded information of potentially criminal behavior (sexual abuse of a ward). This was evidenced by a "Notice of Prison Rape Elimination Act (PREA) Investigation Status" memorandum. The Agency indicated that the criminal investigation was conducted by the Cass County Sheriff's Department. The Agency provided the auditor with a forty-four-page investigative file that tracked the efforts of staff upon initially receiving the allegation through the administrative investigatory efforts and substantiation and referral to the Cass County Sheriff's Department in collaboration with the Fargo Police Department for criminal investigation. Ultimately, on September 10, 2018, the State's Attorney's Office officially declined to prosecute the matter. At the close of the investigation the alleged staff member was no longer employed at the facility.

During the on-site portion of this audit, the Executive Director of Centre, Inc. was interviewed. The Executive Director communicated that he works very closely with the Director of Operations and agency PREA Coordinator to ensure the agency's procedure is followed precisely, ensuring an administrative or criminal investigation is completed for all allegations of sexual abuse or harassment. The Executive Director established that in the event of an allegation, an administrative investigation would be conducted and overseen by the PREA Coordinator in conjunction with his position. In the event of a criminal investigation, the law enforcement agency having jurisdiction is notified and requested to investigate. Both the PREA Coordinator and the Executive Director maintain contact with the detective or other point person to get updates on the progress and outcome of the investigation. This auditor was able to validate this practice as the investigative file included internal correspondence between the Cass County Sheriff's Office and Centre Inc.

During both resident and staff interviews, the auditor questioned whether or not the interviewee was aware of any instances of sexual abuse or sexual harassment while they resided/worked at the facility in

an attempt to verify that all instances of sexual abuse and sexual harassment were disclosed to this auditor. No disclosures were made.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.222(b):
Policy P-19 establishes that "[a]n investigation is conducted and documented whenever a sexual assault or threat is reported . . . [upon receiving an allegation staff shall] notify the local law enforcement agency having jurisdiction of the allegations and confirm their plan for investigation including time line(s)." (*p.* 8–9). Section I(D)(7) further establishes that upon receipt of an allegation of sexual harassment, "[i]f after the initial interview with the victim . . . if the staff person suspects a crime may have been committed, the staff person will notify the local law enforcement agency having jurisdiction." (*p.* 11). Both Policy P-19 that delineates the agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation as well as a Memorandum of Understanding between Centre, Inc. and the Fargo Police Department are published on the Agency's website, found here: http://centreinc.org/prea/

During the pre-onsite portion of this audit, the Agency indicated that over the past 12 months, there had been one allegation being referred for criminal investigation. The Agency provided the auditor with a forty-four-page investigative file that included documentation of the referral to the Cass County Sheriff's Department in collaboration with the Fargo Police Department. This was evidenced by a "Notice of Prison Rape Elimination Act (PREA) Investigation Status" memorandum. Additionally, the packet contained internal incident reports prepared by the investigating Detective of the Cass County Sheriff's Department.

During the onsite portion of the audit, the auditor interviewed the Agency's Director of Operations who oversees all administrative investigations within the facilities. The Director of Operations established that all allegations of sexual abuse and sexual harassment are referred for investigation to the Fargo Police Department, unless the allegation does not involve potentially criminal behavior.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.222(c):
Policy P-19 delineates the agency's responsibilities regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation. Section I(D)(4)(b)(3) requires staff to "[n]otify the local law enforcement agency having jurisdiction of the allegations and confirm [their] plan for investigation including time line(s)" (p. 9). The agency policy fails to describe the responsibilities of the investigating entity as it pertains to allegations of sexual harassment (that is criminal in nature). A Memorandum of Understanding between Centre, Inc. and the Fargo Police Department establishes that the Fargo Police Department "will provide necessary law enforcement investigation pertaining allegations of sexual abuse occurring at Centre Inc., 123 15th St. N. Fargo, ND." Both P-19 and the Fargo PD MOU are published on the Agency's website, found here: http://centreinc.org/prea/

Neither P-19 or the MOU describes the responsibilities of the agency and the investigating entity after the case has been referred for criminal investigation.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.222(d) &(e): the auditor is not required to audit these provisions.

Interim Report Corrective Action:

1. Expand existing relationship with the Fargo Police Department to included investigating allegations of sexual harassment.
2. Develop policy and implement protocols that more thoroughly describe the roles of agency staff and the investigating entity during the entire duration of the investigation.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (c) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. The Director of Operations will update the existing Memorandum of Understanding with the Fargo Police Department to include law enforcement's responsibility to investigate allegations of sexual harassment (duties after the case has been referred for criminal investigation).
2. The Director of Operations will update existing policy and procedure to more thoroughly describe the roles of agency staff and the investigating entity during the entire duration of criminal investigations.

The Auditor's proposed methodology for reassessment was to review policy and procedure updates and/or enhancements, and review updated MOU between the Agency and the Fargo Police Department. The agreed upon timeline for updating policies and procedures as outlined above was February 15, 2020 and to update the existing MOU was March 15, 2020.

On January 31, 2020, the PREA Coordinator/Director of Operations provided the auditor with a policy update to P-19: Sexual Abuse/Assault Prevention & Intervention (*effective* 1/31/2020). P-19 was revised to specifically delineate what actions Centre staff will perform and what actions the law enforcement agency are to perform during an investigation into an allegation of sexual assault and sexual harassment (*see* pages 9-10). The Agency provided the auditor with an email disseminating these revisions to facility staff. On January 29, 2020, the auditor was provided an updated MOU between Centre, Inc. and the Fargo Police Department (FPD); signed by both parties on 1/29/2020. The MOU specifically delineates the roles of Centre, Inc. and FPD as it applies to investigating allegations of sexual abuse and sexual harassment.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.231 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.231: Employee training.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Personnel records
    d. Informational developed by North Dakota Human Services
2. Interviews
    a. Random Staff
    b. PREA Coordinator/Director of Operations

3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.231(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I establishes, "Centre Inc. mandates zero tolerance towards all forms of sexual abuse" (p. 1). Section I(H)(1)–(4) establishes, "(1.) All new employees shall receive instruction on the specifics of the Sexual Abuse Assault Prevention and Intervention Policy and Procedure during their initial employee orientation training. This will include instruction related to the prevention, detection, response and investigation of sexual assaults and staff sexual misconduct; (2.) Volunteers and Contractors who have contact with residents will be trained on the specifics of the Sexual Abuse Assault Prevention and Intervention Policy and Procedure including the agency's zero-tolerance policy and information on how to report such incidents; (3.) Employees will receive refresher training/review of the policy and procedure will be conducted on an annual basis thereafter; [and] (4.) All training will be documented" (p. 14). Section 1(B)(3)(f) establishes "[e]mployees are prohibited from any form of retaliation against a client who makes an allegation of staff sexual misconduct or staff sexual harassment" (p. 12). Additionally, the facility provided this auditor with information that all staff are required to complete a Relias Learning 2-hour course titled, "PREA: Dynamics of Sexual Abuse in Correctional Systems. A review of this course reveals that it covers, "the dynamics of sexual abuse and sexual harassment in confinement; how to detect and respond to signs of threatened and actual sexual abuse; common reactions of sexual abuse and harassment victims; how to communicate effectively with inmates, including those identifying as [LGBTI]; and how to avoid inappropriate relationships with inmates/detainees. Additionally, the facility indicated that all staff are required to watch Just Detention International's 16-minute education video for inmates (available online at: https://www.youtube.com/watch?v=ag-__vbx5Mg&feature=youtu.be). Watching the video establishes that it covers a many of the topics listed above in addition to the facility has a zero policy against sexual abuse or sexual harassment, right to report instances privately and the resident has the right to be free from sexual abuse. Lastly, P-19 lists PREA standard 115.261 that establishes, "(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; [and] (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" (p. 18).

During the onsite portion of this audit, this auditor interviewed 12 staff and conducted six training file reviews. All 12 staff informed this writer that they had received training in each of the enumerated required trainings required under this standard. Upon further questioning around the substance of the training and this auditor asking staff to describe and/or explain how each portion of this training was communicated to them, all staff were able to inform this auditor whether a specific provision was trained in Relias, by the on-boarding staff person, or other trainer. No staff staff was able to identify that North Dakota had a specific mandatory reporting statute and what his/her obligations were under the statute.

Further, no staff was able to identify what residents in their care would fall under the protections of this statute. Outside the existence of the mandatory reporting obligations, it became clear to this auditor that the staff were not trained "on how to comply with relevant laws related to mandating reporting of sexual abuse to outside authorities." When asking about mandatory reporting, all staff indicated that they were required to report the incident to the PREA Coordinator/Director of Operations. A review of six personnel files revealed that all six staff received the aforementioned training (PREA Policy Review, PREA Video, and Relias Learning Training).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision as the agency does not train staff "on how to comply with relevant laws related to mandating reporting of sexual abuse to outside authorities."

115.231(b):
During the pre-onsite portion of this audit, the Facility indicated compliance in this provision and provided a training description from Relias Learning of a training titled, "Working with Women Offenders in Correctional Institutions."

During the onsite portion of this audit, all staff reported that the training provided by Centre Inc. upon hire and during refresher courses is tailored to not only the gender of the residents at the facility, but also to their classification status (being in pre-release/community corrections). Out of the six personnel training files, all staff were evidenced to have received this training. A review of this staff person's training records revealed that they received the training titled, "Working with Women Offenders in Correctional Institutions."

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.231(c):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(H)(3) establishes, "[e]mployees will receive refresher training/review of the policy and procedure will be conducted on an annual basis thereafter" (p. 14). The facility indicated, "PREA training is scheduled on an annual basis at Centre."

During the onsite portion of this audit, the auditor selected 12 random personnel files to review. Out of the 12 personnel files, all 12 evidenced completion of an annual refresher PREA trainings. The two trainings completed were titled, "PREA Video" and "PREA: Dynamics of Sexual Abuse in Correctional Systems." Additionally, each of the 12 random personnel files evidenced completion of an annual policy and procedure review, that included a review of PREA-related policies and procedures.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.231(d):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(H)(4) establishes, "[a]ll training will be documented" (p. 14).

The aforementioned training records are documented in two ways: 1) the annual policy review and acknowledgement is documented by employee signature; 2) the completion of trainings is documented through a password protected that is unique for each employee. Management can then go into Relias Learning as an administrator and audit/review the status of completed trainings and print a master list of completed trainings per employee. The auditor reviewed this process and requested an agency-level staff person to demonstrate how they would audit completion of trainings and ensure that it was the staff person listed.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

1. Train all staff "on how to comply with relevant laws related to mandating reporting of sexual abuse to outside authorities."

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. Centre Inc.'s policy PE-8 "Abuse and Neglect" outline staff's responsibility and requirement to report abuse to the appropriate Social Services agency. This policy and procedure is contained within the agency's Personnel protocols. All staff receive annual training on the Personnel Protocols and documentation of such training is maintained on file. On an annual basis, the Director of Operations will communicate an agency-wide reminder to all personnel to review this specific policy titled, "Abuse and Neglect". This reminder will be provided annually every October.
2. Centre Inc. will enhance its current training curriculum of mandatory reporting of abuse and neglect of a "Vulnerable Adult" as defined by North Dakota law.
3. Centre Inc. will train facility staff in mandatory reporting laws.

The Auditor's proposed methodology for reassessment was to review updated training curriculum and the method for which staff were trained. The agreed upon timeline for completing this corrective action was March 15, 2020.

On December 30, 2019, the PREA Coordinator/Director of Operations provided the auditor with an informational developed by North Dakota Human Services that displays what, when, what to include, and how to report allegations of abuse to applicable residents. On January 30, 2020, the facility provided me photographs of this informational displayed on the information board centrally located at the entrance of the facility. On Friday, February 7, 2020, the auditor conducted a telephone interview with the PREA Coordinator. The PREA Coordinator reported that all staff were made aware of the mandatory reporting laws during one-on-one supervision and review of the updated information board.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.232: Volunteer and contractor training.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)

a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
c. Volunteer and contractor training records

2. Interviews
    a. Volunteer(s) or Contractor(s) who may have Contact with Residents
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.232(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(H)(2) establishes, "Volunteers and Contractors who have contact with residents will be trained on the specifics of the Sexual Abuse Assault Prevention and Intervention Policy and Procedure including the agency's zero-tolerance policy and information on how to report such incidents" (p. 14). Facility indicated in the PAQ that it had one volunteer or contractor who may have contact with residents.

During the onsite portion of this audit, the auditor requested a list of all contractors or volunteers that may have contact with residents. The facility provided this auditor with a list of three contractors or volunteers and one intern and indicated that all three contractors would be accompanied by staff in the event they were inside the program. The facility provided this auditor with all training files of these individuals. A review of the three contractor files revealed that they received a document titled, "PREA Compliance Acknowledgement (Contractors, Venders and Volunteers)." A review of this document evidences that it details the agency's policies and procedures regarding sexual abuse and sexual harassment prevention detection, and response. Additionally, all contractors, venders and volunteers are required to read and sign acknowledgement that they read and understand P-19: Sexual Abuse/Assault Prevention & Intervention Policy and Procedure. A review of the intern personnel file evidenced that this person was required to complete an application as all prospective employees need to. A review of this person's personnel file revealed that the intern received a formal orientation including a review of the agency's PREA policy. While onsite, this auditor interviewed one of the above-mentioned contractors or volunteers. This person reported that prior to working with any resident they received a formal orientation that included a review of the agency's PREA policy and this person's obligation to report to their immediate supervisor any information of an alleged incident of sexual abuse or harassment, retaliation, or staff neglect that may have lead to an incident of sexual abuse or sexual harassment.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.232(b):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(H)(2) establishes, "Volunteers and Contractors who have contact with residents will be trained on the specifics of the Sexual Abuse Assault Prevention and Intervention Policy and Procedure including the agency's zero-tolerance policy and information on how to report such incidents" (p. 14).

As noted in provision (a) of this standard, the facility by their practice evidenced that the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. A review of four contractor and volunteer files revealed that the three individuals that only had contact with residents while accompanied by a designated staff person received an orientation that included a review of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incident, while the volunteer that the facility anticipated would be spending time with the resident alone doing case management work received the same training that a staff person received, including this provision's required training. Additionally, this auditor interviewed a volunteer that confirmed receipt of this training prior to working with any resident within the facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.232(c):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision.

During the onsite portion of this audit, this auditor requested contactor and volunteer files from Centre's Human Resources Department. This auditor received files for all the above-mentioned contractors and volunteers that included signed copies of Centre's acknowledgment of receipt and understanding of the Sexual Abuse/Assault Prevention & Intervention Policy and Procedure, Confidentiality Agreement, and "PREA Compliance Acknowledgement (Contractors, Venders and Volunteers)" for each contractor or volunteer.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Standard 115.233: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? ☒ Yes ☐ No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.233: Resident education

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. – 123 15th Street Fargo Facility ("15th Street") Pre-Audit Questionnaire (PAQ) responses
    b. Resident Handbook
    c. Justice Detention International PREA Video (*published* 2/27/2014)
    d. Resident Confidential Case Files
    e. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    f. Referral, Admissions, Intake, & Orientation Processing Policy P-11 (*revised* 11/30/2018)
    g. An Overview for Clients on Sexual Abuse/Assault Prevention and Intervention Signature Acknowledgment Page
    h. Resident Case Note
2. Interviews
    a. Intake Staff
    b. Random Residents
3. Site Review Observations:
    a. Observations during on-site review of physical plant
    b. PREA education materials/posted PREA Notices

Findings (By Provision):

115.233(a):

Centre has Policy P-11: Referral, Admissions, Intake, & Orientation Processing. Section II(h) of P-11 establishes that upon a resident admission "[o]n-duty staff provides the resident with a copy of the educational packet on 'Centre's Sexual Abuse/Assault Prevention and Intervention Program.' A staff person and the resident review the packet. Staff answers questions as needed. Staff and the resident sign the acknowledgment, and a copy I placed in the resident's case file" (*p.* 18). the protocols for "Investigations of Non-Consensual Sexual Acts, Abusive Sexual Contacts, Client Sexual Harassment, Staff Sexual Misconduct, or Staff Sexual Harassment" (*p.* 8). Centre has documented procedures establishing that all allegations of sexual abuse and sexual harassment, as delineated above, are investigated (*p.* 8–13). This "packet" is Section 3 of the Resident Handbook and includes information about the facility's zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The facility indicated that over the past 12 months 1,022 residents were admitted and given this information at intake (please note: this number includes the Residential Transitional Reentry Center for Females).

During the onsite portion of the audit, the auditor interviewed the interviewed intake staff. Intake Staff in this facility include Residential Counselors and Case Managers. Upon admission (as it pertains to this

standard), the resident is provided and reviews with staff the orientation binder that includes the PREA-related materials. Within 48 hours of the resident's admission, he meets with his assigned Case Manager who reviews the resident's understanding of the materials provided at intake and commences with the resident's case management intake. In addition, prior to going over facility specific policies and procedures during review of the orientation binder, all residents watch a sixteen-minute video developed by Justice Detention International that reviews the facility's zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents.

Twenty residents were formally interviewed during the onsite portion of this audit. During random and targeted resident interviews, residents were asked specifically if they received information or 1) your right to not be sexually abused or sexually harassed, 2) how to report sexual abuse or sexual harassment, 3) your right not to be punished for reporting sexual abuse or sexual harassment, and 4) whether the resident received information about the facility's rules against sexual abuse and harassment. Every resident, without hesitation, answered that they received all of the above-listed information and that staff did so within hours of them arriving to the facility.

A random sample of 13 resident files were selected of active residents by the auditor to review to ensure documentation of the resident's participation in the above-listed informational sessions. All resident files included a signed copy of "An Overview for Clients on Sexual Abuse/Assault Prevention and Intervention Signature Acknowledgment Page." The form states: "I have read the above educational information which addresses: the subject of sexual abuse/assault which included but was not limited to: recognizing behaviors that are inappropriate, harassing, or assaultive; how to seek protection; privacy rights; medical and psychological programs for victims of abuse; how to confidentially report sensitive issues to facility staff, the referral agent, and/or local law enforcement. I have been given the opportunity to have questions answered regarding the above information by a staff member." This document was used by the auditor to verify participation in the education session.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.233(b):
Centre's Policy P-11: Referral, Admissions, Intake, & Orientation Processing does not differentiate between admissions for residents who are transferred from a different community confinement facility from any other admission.

During the pre-onsite portion of this audit, the Facility indicated that a "[f]ull orientation [is] completed upon intake for all admissions." The Facility indicated that over the past 12 months, there had been one resident transferred from a different community confinement facility. However, this resident had discharged prior to the first day of the onsite portion of the audit.

During the onsite portion of the audit, as indicated above in provision (a), all resident interviews conducted onsite and resident case file audits of a random sample of residents currently in the facility indicated that all residents receive education pertinent to this provision upon admission to the facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.233(c):
Centre has Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section II(A)(3) of P-19 establishes that "[a]ppropriate provisions will be made as necessary for clients with limited English proficiency, clients with disabilities, and clients with low literacy levels . . . The Program Director/Manager and Case Manager will develop a plan specific to each unique situation designed to ensure all residents have 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" (*p.* 6).

During the onsite portion of the audit, this auditor reviewed resident education materials provided to the residents (Just Detention International PREA video, Resident Handbook excerpts, and a print out of the large notice displayed throughout the facility) as well as materials posted throughout the facility. All postings/materials were in English. A review of resident utilization over the past 12-months and interview with the PREA Coordinator revealed that this corresponds to the resident demographics of this facility. On the first day of the onsite portion of the audit, the facility indicated they currently had no residents with physical disabilities, a cognitive disability, or who were limited-English proficient. The auditor attempted to corroborate this report through general observations throughout the onsite portion of this audit and through random staff and resident interviews. No residents were identified that met this criterion.

During random staff interviews, this writer was made aware that there had been a resident that was hearing impaired had previously resided at the male unit. The facility contracted with an American Sign Language (ASL) interpreter that interpreted the orientation/educational materials via video conference. This particular resident was identified and was no longer in the facility to corroborate this report. However, this auditor was able to review a resident case note in this resident's confidential case file that indicated that on "10/31/2016: Intake and first session completed during . . . meeting . . . ASLIS [American Sign Language Interpreting Services] Interpreter present." Additionally, multiple Residential Specialists revealed that they had conducted an intake where they read aloud the pertinent sections of the Resident Handbook and educational materials to ensure the resident understood the information being reviewed. Staff reported that this would be done for residents with learning difficulties and for the visually impaired. Both the Executive Director and PREA Coordinator indicated that interpreters would be hired at the expense of the agency. These services would be coordinated prior to the resident's arrival to ensure that resident received timely information upon intake.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.233(d):
A random sample of 13 resident files was selected by the auditor to review to ensure documentation of the resident's participation in the above-listed informational sessions. All resident files included documentation of a signed copy of "An Overview for Clients on Sexual Abuse/Assault Prevention and Intervention Signature Acknowledgment Page." As reviewed in provision (a) of this standard, this acknowledgement covers information pertaining to the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or 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.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.233(e):
During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided an electronic version of the "Centre Inc. Prison Rape Elimination Act (PREA) Notice to Residential Program participants."

During the onsite portion of this audit, this auditor observed the above-referenced PREA Notices posted throughout the facility: near elevators, in common areas, on each floor. The displayed PREA Notices were large (poster board-sized documents) that included information about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or 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. These postings were displayed at the entrance of the facility. The first thing this auditor notices when walking into this facility was the notice. Additionally, while onsite the auditor requested and was provided with a copy of the Resident Handbook. This auditor witnessed a new arrival be provided a Resident Handbook to review while staff was organizing his intake materials. Additionally, during the facility review, this auditor witnessed Resident Handbooks in resident rooms.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as key information about the agency's PREA policies was demonstrated to be continuously and readily available or visible for this facility's residents.

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.234: Specialized training: Investigations.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. North Dakota Law Enforcement Training Academy Training Agenda
    c. PREA Investigator Training Rosters

d. Program Description of the 20-hour PREA Investigator Training facilitated by The Moss Group

2. Interviews
    a. Investigative Staff
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.234(a):

During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided this auditor with a training certificate for four staff, indicating completion of a training titled "Department of Correction and Rehabilitation Certificate of Completion [for] PREA Investigator Training." Additionally, the facility provided the training agenda for this training; topics included: PREA Refresher and Overview of the PREA Investigative Standards; The Audit Process; Trauma and Victim Response; Agency Policy; Prosecutorial Collaboration.

During the onsite portion of the audit, this auditor interviewed the agency's lead investigator. This person indicated they have received the following training: (1) training titled "The National PREA Standards: Implications for Human Resource Practices in Correctional Settings" sponsored by the National PREA Resource Center; (2) completed a 3-hour on-line training titled, "PREA: Investigating Sexual Abuse in a Confinement Setting" presented by the National Institute of Corrections; (3) completed a 20-hour PREA Investigator training provided by The Moss Group and hosted by the North Dakota Department of Corrections and Rehabilitation; and (4) completed a 2-day training titled, "Investigating Sexual Misconduct: Training for Correctional Investigators" facilitated by the North Dakota Department of Corrections and Rehabilitation. During the onsite portion of this audit, this auditor was able to corroborate completion of these trainings by reviewing this staff person's personnel records; all certificates of completion were present in their personnel file.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.234(b):

During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided this auditor with training certificates for all seven agency staff completing the investigator training. The facility indicated the agency has a total of seven agency investigators available for Centre's programs located in Fargo North Dakota.

During the onsite portion of this audit, this auditor interviewed an agency investigator. This staff person reported that the 2-day training titled, "Investigating Sexual Misconduct: Training for Correctional Investigators" facilitated by the North Dakota Department of Corrections and Rehabilitation covered 1) techniques for interviewing sexual abuse victims; 2) proper use of Miranda and Garrity warnings; 3) Sexual abuse evidence collection in confinement settings; and 4) criteria and evidence required to substantiate a case for administrative action or prosecution referral. This auditor was able to corroborate completion of this training by reviewing the identified person's training records; all certificates of completion were present in their personnel files.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.234(c):
As noted in provisions (a) and (b), this auditor was able to review documentation showing that agency investigators had completed the required training.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

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

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☐ Yes ☐ No ☒ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☐ Yes ☐ No ☒ NA

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)
  ☐ Yes ☐ No ☒ NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☐ Yes ☐ No ☒ NA

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.235: Specialized training: Medical and mental health care.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Staff List
2. Interviews
    a. PREA Coordinator
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):
115.235(a)-(c):

During the pre-onsite portion of this audit, the Facility indicated that Centre, Inc. does not employ medical or mental health staff.

During the onsite portion of this audit, this auditor attempted to corroborate the Facility's PAQ response by reviewing a staff list of program personnel and by interviewing the PREA Coordinator who is also the Agency's Director of Operations. The PREA Coordinator confirmed that Centre, Inc. does not employ any medical or mental health staff and that residents obtain these services through community-based organizations. A review of the staff list provided revealed no medical or mental health staff listed.

Based upon the review and analysis of all the available evidence, the auditor has determined that this provision is not applicable to this agency.

115.235(d):
During the pre-onsite portion of this audit, the Facility indicated that Centre, Inc. does not employ medical or mental health staff nor does Centre have any practitioners contracted with and volunteering for the agency.

During the onsite portion of this audit, this auditor attempted to corroborate the Facility's PAQ response by reviewing a list of contractors and volunteers and by interviewing the PREA Coordinator who is also the Agency's Director of Operations. The PREA Coordinator confirmed that Centre, Inc. does not have any medical or mental health practitioners under contract or volunteering at the facility. A review of the current list of contractors and volunteers revealed no medical or mental health practitioners listed.

Based upon the review and analysis of all the available evidence, the auditor has determined that this provision is not applicable to this agency.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility? ☒ Yes ☐ No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? ☒ Yes ☐ No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? ☒ Yes ☐ No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☒ Yes ☐ No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? ☒ Yes ☐ No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.241: Screening for risk of victimization and abusiveness

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 12/11/2019)
    d. Referral, Admissions, Intake, & Orientation Processing P-11 (*reviewed* 11/30/18)
    e. Centre, Inc. Initial Assessment/Re-Assessment Prison Rape Elimination Act (PREA)
    f. Centre, Inc. Initial Assessment/Re-Assessment Prison Rape Elimination Act (PREA) (*revised* 10/11/2019)
    g. Resident confidential case files
    h. Resident Log and Classification Email
    i. Email Correspondence
2. Interviews
    a. Random Residents
    b. Staff responsible for risk screening
    c. Random Staff
    d. PREA Coordinator/Director of Operations
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.241(a) and (b):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(A) establishes, "Centre will act to prevent and/or reduce sexual assault of clients through . . . screening [and] assessment" (p. 1). Section II(B)(1) establishes, "[c]lients will be screened within 48 hours of arrival at all residential facilities for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior" (p. 6). The facility indicated that over the past 12 months 1,022 residents were admitted and given this information at intake (please note: this number includes the Residential Transitional Reentry Center for Females). 100% of which were reported to have been screened within 72 hours of their entry into the facility.

During the onsite portion of this audit, this auditor reviewed 13 random resident confidential case files. All 13 files indicated that the resident completed "Centre Inc. Initial Assessment/Re-Assessment PREA" on the date of admission to the facility. Every risk screening was evidenced to be conducted on the

resident's admission date. A review of this form reveals that it requires staff to assess the screened resident using eight "vulnerability factors" and six "aggressive/predatory factors." This auditor interviewed 16 residents. All residents reported that staff conducted this questionnaire within hours of their arrival to the facility.

This auditor also interviewed staff responsible for risk screening. This facility does not employ a traditional staff person responsible for the intake of residents. Instead, all Residential Specialists – direct care staff – are responsible for conducting the risk screening. Additionally, within 48hrs, the resident meets with his assigned case manager who reviews the risk screening in preparation for a risk/needs assessment in order to inform an individualized treatment plan for that resident. As a result, this auditor asked questions that pertained to the risk screening of residents in every interview conducted with either a case manager or residential specialist. Eight staff were interviewed that were either case managers or residential specialists. All eight staff corroborated this process: the very first thing done with that resident, it was consistently reported to this auditor, was to conduct his risk screening in order to appropriately assign that resident a bedroom/bunk.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility exceeds this provision. These two provisions call for a risk screening to be conducted and be conducted within 72hrs of admission. Agency procedure requires that the resident be screened within 48hrs. This facility has demonstrated that this risk screening and classification is conducted within hours of a resident's arrival.

115.241(c):
During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided this auditor with a copy of their risk-screening form: "Centre Inc. Initial Assessment/Re-Assessment PREA." A review of this form indicates that it requires screening staff to assess the screened resident using eight "vulnerability factors" and six "aggressive/predatory factors" through a series of yes and no questions. Screening staff is then required to review the answers provided and "[i]f question 1 is scored yes the offender is a Known Victim," "[i]f three or more [vulnerability factors] questions are scored, the offender is a Potential Victim" and "[i]f two or less are scored the offender is Unrestricted" (same analysis for aggressor). As a result, the facility's screening instrument is objective as the results are measurable and the same results could be reproduced by other staff.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.241(d):
A review of the facility's risk screening tool, titled: "Centre Inc. Initial Assessment/Re-Assessment PREA," establishes that it assesses the following (exhaustive list):
Vulnerability Factors:
1) Does the resident have a history of being a victim of predatory or aggressive sexual actions in an institutional setting?
2) Does the resident have any history of being a victim of predatory or aggressive sexual actions including domestic violence?
3) Is the resident younger than 25 or older than 64?
4) Is the male resident small in stature (height of 5'6" or less or weigh 140 lbs or less)?

5) Is the female resident small in stature (height of 5' or less or weigh 100 lbs or less)?
6) Is the resident intellectually/cognitively challenged, mentally ill, have a physical or medical disability, or a mental health condition that may make them vulnerable in a correctional facility?
7) Is the resident Lesbian/Gay/Bisexual/Transgender/Intersex/Gender Non-Conforming?
8) Does the resident verbalize fear for personal safety or sexual victimization?

Aggressive/Predatory Factors:
1) Does the resident have a history of institutional sexual predatory behavior (including jail and prison)?
2) Does the resident have a history of institutional sexual activity?
3) Does the resident have any history of non-contact predatory behavior?
4) Has the resident been professionally diagnosed with a paraphilia(s) in the past 15 years?
5) Has the resident been the defendant in a domestic abuse protective order?
6) Does the resident have any history of assaultive behavior (physical or sexual)?

A review of this screening tool reveals that is does not ask the resident: whether the resident has previously been incarcerated or whether the resident's criminal history is exclusively nonviolent.

During the onsite portion of the audit, this auditor interviewed multiple staff (as indicated in provisions (a) and (b)) that are responsible for risk screening. All staff indicated that they complete the intake form titled, "Centre Inc. Initial Assessment/Re-Assessment PREA."

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.241(e):
A review of the facility's risk screening tool, titled: "Centre Inc. Initial Assessment/Re-Assessment PREA," as outlined in subsection (d) of this standard establishes that it considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.241(f):
During the pre-onsite portion of this audit, the Facility provided P-11: Referral, Admissions, Intake, & Orientation Processing in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section 5 establishes "[t]he Case Manager will complete the PREA Risk Re-Assessment within 25 days of arrival to facility" (p. 11). The facility indicated that over the past 12 months 793 residents were admitted to the facility whose length of stay in the facility was for 30 days or more who were reassessed for their risk of sexual victimization or of being sexually abusive within 30 days after their arrival (the above-referenced figure reflects both the female and male units).

During the onsite portion of the audit, this auditor conducted 13 random resident confidential file reviews, 10 of which were for residents currently in the facility longer than 30 days. Eight files contained re-assessments within 30 days after a resident's arrival at the facility, two contained re-

assessments that occurred after this window. This auditor interviewed 16 random residents, 14 residents reported to this auditor that they were not asked risk screening questions after their initial intake with their case manager/screening staff. This auditor also interviewed three case managers – the staff designated as being responsible for conducting the re-assessment at the facility. All three case managers indicated that they conduct a re-assessment within 25 days of the resident's admission.

A review of confidential resident files revealed that approximately 20% of the re-assessments were not conducted within the requisite window. Additionally, nearly all residents interviewed reported that they have not been asked the risk screening questions again since intake.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.241(g):
During the pre-onsite portion of this audit, the Facility provided P-11: Referral, Admissions, Intake, & Orientation Processing in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section 5(ii) establishes, "[i[f there is any new information discovered the Case Manager will follow the First Responder Protocol and clearly document any new information, new clinical data, or new self-disclosure and complete any necessary follow-up needed per policy" (p. 11). Policy P-19 further establishes that "[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" (p. 16 unenumerated section).

During the onsite portion of the audit, this auditor interviewed three case managers – the staff designated as being responsible for conducting the re-assessment at the facility. All three case managers indicated that they would conduct a re-assessment in the event that there was a new report or incident of sexual abuse, information unknown at the time of intake from the referral source, a request, or if they were in receipt of any additional information that bears on a resident's risk of sexual victimization or abusiveness. Additionally, while onsite, this auditor received notification that an example of this was available. This particular incident involved a risk assessment initially being conducted upon arrival and when this particular resident's institutional paperwork was received and reviewed the case manager discovered a prior unreported incident. As a result, a re-assessment was conducted (which in turn changed his classification and room). This re-assessment was evidenced to have been completed the same day the staff became aware of the new information. This was evidenced by a review of this resident's confidential case file and review of internal correspondence to the facility head and PREA Coordinator of this resident's updated classification.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.241(h):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes, "Residents may not be disciplined for refusing to answer, or for

not disclosing complete information in response to, questions asked [during their risk screening]" (p. 16).

During the onsite portion of the audit, this auditor interviewed three case managers – the staff designated as being responsible for conducting the re-assessment at the facility. All three case managers indicated that under no circumstances would a resident be disciplined for not answering any questions during the PREA screening. The staff reported that they would ask all questions and if the resident chose not to answer any or all questions, the staff would try to obtain the information through the resident's intake paperwork or from the referral source.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.241(i):
During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that the Agency has 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. The PREA Coordinator reported that the agency's "Referral, Admissions, Intake and Orientation" Policy and Procedure outlines the Case Manager's and Clinical Program Manager's responsibility specific to this standard and the "Confidentiality" policy covers the "Need to know within the agency" rule specific to accessing client records.

This auditor also conducted interviews of eight staff that were either case managers or residential specialists (those tasked with conducting the risk screening). During these interviews it was revealed that all staff throughout the program had access to the completed risk screening forms for all residents. It was additionally revealed that many staff that only worked in this facility had access to other Centre, Inc. facilities' resident's risk screening information and results.

There are no controls being utilized to control the dissemination within the facility of responses to questions asked pursuant to this standard to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. This provision does not limit the classification of a particular resident to all security personnel, its target and focus is on the sensitive information that was provided and utilized to make that classification.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:
1. Develop and implement a risk screening tool that assesses whether the resident has previously been incarcerated or whether the resident's criminal history is exclusively nonviolent.
2. Develop a tickler system to ensure staff are reassessing each resident's risk of victimization or abusiveness within a set period of time, not to exceed 30 days after the resident's arrival.
3. Establish and implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (d), (f), and (i) of this standard. The Auditor initially identified provision (e) of this standard as being not compliant. However, after further review of the information available to the auditor at the time the interim report was drafted, this finding was changed as the facility adequately demonstrated that the intake screen tool considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to these provisions:

1. The Director of Operations updated the agency's Risk Screening Tool titled, "INITIAL ASSESSMENT/RE-ASSESSMENT PRISON RAPE ELIMINATION ACT" to include a question which states, "Is the resident's criminal history exclusively nonviolent?" This update occurred on 10-11-19. Existing questions on this document account for the resident's history of incarceration and prior institutional violence. Centre Inc. Case Managers are required to reassess risk within 25 days of first becoming aware of the need per policy. Case Managers utilize their Outlook Calendars and set "Alert Reminders" which trigger this task. The Director of Operations will direct Program Directors to remind all Case Managers to follow this process by 10-18-19.
2. The Director of Operations will update P-19 "Sexual Abuse/Assault Prevention and Intervention" policy and procedures to clearly establish and communicate expectations around internal dissemination of all PREA Assessments and Re-assessments. Updated protocol will establish criteria that safeguards sensitive information to ensure it is not exploited by staff or residents.

The Auditor's proposed methodology for reassessment was to review updated policies and procedures, review documentation of the dissemination of the updated policy and procedure, and review completed re-assessments to ensure completion within 30 days of the initial assessment. The agreed upon timeline for completing this corrective action was February 1, 2020 for updating and disseminating revised policy and procedures and information controls; and March 15, 2020 for evidencing that re-assessments are occurring within 30 days of the initial risk assessment.

On October 22, 2019, the PREA Coordinator/Director of Operations provided the auditor with the Agency's updated Initial Assessment/Re-Assessment form, revised 10/11/2019. Additionally, the Agency provided the auditor with email correspondence dated October 15, 2019 that the updated form was available on SecurManage. Additionally, the PREA Coordinator/Director of Operations provided the auditor with email correspondence dated October 11, 2019 to all case management staff that included the following text: "Centre Inc. Case Managers are required to reassess risk within 25 days of first becoming aware of the need per policy. Case Managers utilize their Outlook Calendars and set "Alert Reminders" which trigger this task." On December 11, 2019, the PREA Coordinator/Director of Operations provided the auditor with a policy revision to P-19: Sexual Abuse/Assault Prevention and Intervention. This revision added, "Dissemination of resident Intake Screening information within the facility will be done so on a "Need To Know" basis amongst personnel. Sensitive information will not be exploited by staff or other residents. Staff accessing "INITIAL ASSESSMENT/RE-ASSESSMENT PRISON RAPE ELIMINATION ACT" document for any purpose other than to make informed decisions within the scope of their assigned duty is prohibited. Centre Inc. personnel who do not have job responsibilities specific to this standard will not be granted access to this specific information within the agency's electronic case file system "SecurManage" (p. 6). On February 7, 2020, the auditor conducted

a telephone interview with the PREA Coordinator. The PREA Coordinator reported that the policy revision was disseminated to staff via email and by posting the update on the control center message board. Additionally, the PREA Coordinator confirmed that staff who do not have job responsibilities specific to risk screening assessments have been denied access to these screening tools through SecurManage. On March 15, 2020, the auditor reviewed three randomly selected re-assessments of residents that were in the facility for 30 days from February 1, 2020. All three files evidenced completion of the risk screening re-assessment within 30 days of the initial risk screening.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.242: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement

would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.242: Use of screening information

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*revised* 1/31/2020)
    d. Email correspondence between screening staff and assigned case manager, facility manager, and PREA Coordinator
    e. Email correspondence to case management staff
2. Interviews
    a. Random Residents
    b. PREA Coordinator
    c. Staff responsible for risk screening
    d. Residents that identify as lesbian, gay, bisexual, transgender, or intersex
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.242(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes, "[t]he agency shall use information from the risk screening . . . 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. Additionally, the facility provided this auditor with an email/Resident Log of a resident's classification as a "Potential Victim" and its use of that assessment to inform this resident's housing and bed assignment.

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator and staff responsible for risk screening. The PREA Coordinator reported that the facility utilizes a screening

assessment to determine whether or not each incoming resident is a Known Aggressor, Potential Aggressor, Known Victim, Potential Victim or Unrestricted. The facility does not house Known or Potential Aggressors with Known or Potential Victims. This is communicated to all direct care staff by placing a code (KA, PA, KV, PV) on the resident's electronic case file banner. Throughout the onsite portion of this audit, this auditor was able to verify the practice of utilizing the resident classification banner on SecurManage. Staff responsible for risk screening reported that the risk assessment is utilized to inform the staff what room and bed assignment the resident can reside in. The staff reported that they would never place a known or potential victim with a known or potential abuser. All randomly selected staff revealed that the residents are placed in a room/bed assignment consistent with their risk-level. No staff, however, reported that the risk screening is utilized to inform work, education, and program assignments; where risk screening staff indicated that they did not utilize the results for those assignments.

Risk screening results are not being utilized to inform work, education, and program assignments.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.242(b):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes, "[t]he agency shall make individualized determinations about how to ensure the safety of each resident" (p. 17).

During the onsite portion of this audit, this auditor interviewed staff responsible for risk screening. Staff responsible for risk screening reported that upon intake the screening staff makes an individualized determination based on the resident's risk level about how to ensure the safety of each resident. Staff reported that the facility houses residents in a way that ensures their safety and if at anytime the resident reports any fear, their housing placement is reassessed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.242(c):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes, "[i]n 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" (p. 17).

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that prior to entry, the Program Director or designee would consult with the referring institution or agency. Care and consideration would be given to the client's needs and when

possible and where safety issues do not exist, they are housed where they feel comfortable with the referral agency's consent. Additionally, the PREA Coordinator reported that the agency considers whether the placement will ensure the resident's health and safety and whether the placement would present management or security problems.

At the time of the onsite portion of this audit, the facility reported that there were no residents that identified as either transgender or intersex in the facility. This auditor attempted to corroborate that through resident confidential file reviews and through random staff interviews. No residents were identified that met this criteria.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.242(d):
During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that transgender and intersex resident's own views with respect to his or her own safety are given serious consideration in placement and programming assignments. Additionally, this auditor interviewed staff responsible for risk screening. This staff person reported that a resident's own views with respect to his or her own safety would be given serious consideration. This staff person could only recall one transgender resident residing at this facility while this person had been an employee. This person reported that this resident's own views with respect to her safety were given serious consideration and she was housed in a bed assignment which she approved.

As noted in provision (c), no transgender or intersex residents were interviewed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.242(e):
During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that transgender and intersex residents would be able given the opportunity to shower separately from other residents that that they would be afforded the opportunity to utilize the single shower bathroom. Additionally, this auditor interviewed staff responsible for risk screening. This staff person reported that a transgender or intersex residents would be housed in the North Unit so that they could be housed in a bedroom that has a single shower bathroom.

As noted in provision (c), no transgender or intersex residents were interviewed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.242(f):
During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that LGBTI residents are not placed in dedicated facilities, units, or wings solely on the basis of such identification or status. The PREA Coordinator further reported that Managers

responsible for housing assignments understand the significance of not discriminating against residents based on their sexual preference.

During the onsite portion of this audit, the facility provided me with a list of 11 residents that identified as either lesbian or bisexual. Six of these residents were interviewed. All residents reported that they felt safe in his housing placement and reported that they were not placed in a housing area only for gay, lesbian, bisexual, transgender, or intersex residents.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

Interim Report Corrective Action:

1. Utilize risk screening results to inform 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.
2. Develop and implement a risk screening tool that assesses any history of prior institutional violence

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (a) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. The Director of Operations will update P-19 "Sexual Abuse/Assault Prevention and Intervention" and P-11 "Referral, Admissions, Intake, and Orientation Processing" Policy and Procedure to include guidance for Case Managers and Residential staff to utilize risk screening results to assist with ensuring potential victims / those at risk of being sexually victimized will be separated from potential aggressors / those at high risk of being sexually abusive when assigning programming, work and education where possible.

2. The Director of Operations updated the agency's Risk Screening Tool titled, "INITIAL ASSESSMENT/RE-ASSESSMENT PRISON RAPE ELIMINATION ACT" to include a question which states, "Does the resident have any history of institutional violence?" This was completed and implemented 10-15-19.

The Auditor's proposed methodology for reassessment was to review updated policies and procedures, review revised risk screening tool(s), and review documentation that the risk screening assessment was being utilized when assigning programming, work, and education. The agreed upon timeline for completing this corrective action was February 1, 2020 for updating and disseminating revised policy and procedures; and March 15, 2020 for evidencing that risk screening assessments were being utilized when assigning programming, work, and education assignments.

On October 22, 2019, the PREA Coordinator/Director of Operations provided the auditor with the Agency's updated Initial Assessment/Re-Assessment form, revised 10/14/2019. Additionally, the Agency provided the auditor with email correspondence dated October 15, 2019 that the updated form was available on SecurManage. On January 31, 2020, the PREA Coordinator/Director of Operations provided the auditor with a policy revision to P-19: Sexual Abuse/Assault Prevention and Intervention. This revision added, "Case Managers, Residential Staff and Program Managers will utilize risk screening

results to assist with ensuring potential victims (those at risk for being sexually victimized) will be separated from potential aggressors (those at high risk of being sexually abusive) when assigning programming, work and education where possible." (p. 7). On February 3, 2020, the auditor was provided email correspondence from Agency administration to all case management staff at the facility detailing the policy revision. On February 7, 2020, the auditor conducted a telephone interview with the PREA Coordinator. The PREA Coordinator reported that the more expansive use of the risk screening assessment is reviewed during case management meetings. Additionally, there were currently no residents that scored as a potential aggressor in the facility. As a result, there were no case notes to review of case management efforts to keep residents classified as potential victims separate from residents classified as potential aggressors when assigning programming, work, and education assignments.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

REPORTING

Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.251: Resident reporting.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019*)*
    c. PREA Notice
    d. Centre, Inc. & Fargo Police Department MOU (*effective* 1/31/2020)
2. Interviews
    a. Random Residents
    b. Random Staff
    c. PREA Coordinator
    d. Police Department Personnel
3. Site Review Observations:
    a. Observations during on-site review of physical plant; review of information displayed throughout the facility

Findings (By Provision):

115.251(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section II(C)(1) allows for "[c]lients, uninvolved inmates, or staff . . . [may report incidents] verbally or in writing to a staff member" (p. 7). Attachment A establishes that the agency provides 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" (p. 17). The facility also provided this auditor with a PREA Notice (evidenced to be displayed throughout the facility during the site review) that indicates, any can "report [sexual abuse, sexual harassment, or staff sexual misconduct] in one of the following ways: verbally, in writing, anonymously, [and] by a third party."

During the onsite portion of this audit, this auditor interviewed 12 staff and 16 residents. All staff initially indicated that residents can report these incidents to any staff member or their case manager. When this auditor pushed for elaboration, staff reported that residents can report in writing, verbally in person, or through a third party. When asked when staff were trained in this, staff consistently reported during orientation when they reviewed policies and their Employee Standards of Conduct. All resident answers varied but a review of all responses indicated that the resident was able to identify at least two

ways to report; the most common answers were in-person, through a third party, hotline number, or local police (or contracting authority).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the facility has demonstrated that residents are able to make such reports utilizing multiple internal ways.

115.251(b):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section II(A)(1)(c) requires that during client orientation, residents are provided information on "[r]eporting sexual abuse and privacy rights including how to confidentially report sensitive issues to facility staff, the referral agent, local law enforcement; and/or the Office of Inspector General" (p. 6). The facility also provided this auditor with a PREA Notice (evidenced to be displayed throughout the facility during the site review) that establishes a resident can "Contact the PREA Compliance Manager at your respective facility [and provides their direct line], Contact Centre Inc.'s PREA Coordinator [and provides his Office line; testing the voicemail onsite revealed that the PREA Coordinator leaves his work cell number in his voicemail], Contact the PREA Director at the Dept. of Corrections Central Office [and leaves their physical address], Contact the Bureau of Prisons Residential Reentry Manager [and leaves a telephone number accessible during normal business hours], [and] Report it directly to local law enforcement by calling 9-1-1."

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that the facility displays publicly posted posters including local law enforcement telephone number and the North Dakota Dept. of Corrections PREA Coordinator office address for verbal and written reporting. The PREA Coordinator further reported that Residents may anonymously report through 3rd party individuals written, in-person or telephonically and or report via unsigned written correspondence. This auditor also interviewed 16 randomly selected residents. All 16 residents indicated that they could report sexual abuse or sexual harassment to someone who does not work at this facility. Additionally, all but one resident reported that staff would investigate/follow-up on a report given in writing with the resident's name on it.

The facility provided me with an MOU between Centre, Inc. and the Fargo Police Department. This MOU is limited to the investigation of sexual abuse incidents. There is nothing in the MOU that indicates they would immediately forward resident reports to agency officials or that the resident may remain anonymous upon request or that they would immediately forward resident reports to the facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not compliant with this provision as the facility has not demonstrated the residents are able to report anonymously through an outside source that will immediately forward resident reports to the facility.

Prior to a period of corrective action, the auditor determined that the agency is not compliant with this provision as the facility has not demonstrated the residents are able to report anonymously through an outside source that will immediately forward resident reports to the facility.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.251(c):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section II(D)(4)(a)(4) establishes that it is the [r]esponsibilit[y] of the person receiving the report . . . [to] document the incident as reported to you, in writing, for the investigator" (p. 9). The facility also provided this auditor with a PREA Notice (evidenced to be displayed throughout the facility during the site review) that indicates, any can "report [sexual abuse, sexual harassment, or staff sexual misconduct] in one of the following ways: verbally, in writing, anonymously, [and] by a third party." The facility indicated in the PAQ that staff are required to immediately document verbal reports.

During the onsite portion of this audit, this auditor interviewed 12 randomly selected staff and 16 randomly selected residents. All staff indicated that they would accept a report that was made verbally, in writing, anonymously, and from third parties. Staff also indicated that they are required to immediately report this report by employing the chain of command and that they would be required to complete a serious incident report, documenting the report – including verbal reports. All 16 residents reported that they could make a report in writing, verbally, or by way of a third party without having to give your name.

The facility reported that the Agency had received and investigated one report of staff sexual misconduct. This report came in by way of a verbal third-party report. This auditor was able to review an investigative file of this allegation that included the initial incident report and notifications by the receiving staff. This report reduced the verbal report made by the third-party to writing and was signed and dated the same day the allegation was received.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.251(d):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes staff may "privately report sexual abuse and sexual harassment of residents by accepting verbal, written and anonymous reports" (p. 17). Section II(H)(1)–(3) establishes, "[a]ll new employees shall receive instruction on the specifics of the Sexual Abuse Assault Prevention and Intervention Policy and Procedure during their initial employee orientation training. This will include instruction related to the prevention, detection, response and investigation of sexual assaults and staff sexual misconduct . . . [and] [e]mployees will receive refresher training/review of the policy and procedure will be conducted on an annual basis thereafter" (p. 14).

During the onsite portion of this audit, this auditor interviewed the 12 randomly selected staff. All staff indicated that their supervisor, the Facility Director, and the PREA Coordinator all have an open-door

policy and encourage staff to come to them with any issues (beyond not only instances involving PREA).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

1. Develop at least one way for residents to report sexual abuse or sexual harassment to a public or private entity that is not part of the agency where that entity will immediately forward the resident report to agency officials and that allows for the resident to remain anonymous upon request.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (b) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. The Director of Operations will update the current Memorandum of Understanding with the Fargo Policy Department to include the requirement of immediately forwarding all resident reports to Centre Inc.'s PREA Coordinator (Director of Operations) and or the PREA Compliance Officer (Program Directors). The update will include language that allows the resident to remain anonymous upon their request.

The Auditor's proposed methodology for reassessment was to review updated MOU between the Agency and the Fargo Police Department and to test the anonymous reporting system. The agreed upon timeline for completing this corrective action was March 15, 2020.

On January 31, 2020, the PREA Coordinator/Director of Operations provided the auditor with an updated Memorandum of Understanding (hereafter, "MOU') between Centre, Inc. and the Fargo Police Department (FPD); signed by both parties' executive officers on 1/29/2020. The MOU specifically states, the Fargo Police Department will "consider third-party and anonymous reporting" (p. 2). Further, the Fargo Police Department is listed on PREA Notices displayed throughout the facility as an agency in which residents can anonymously report. After receipt of the updated MOU, the auditor contacted the Fargo Police Department. The auditor identified who he was and asked the operator whether they would take an anonymous report by an individual calling from the facility. The operator stated that the Fargo PD would follow-up on any report of sexual abuse to the best of their capabilities based on the information the individual was willing to share with the police, and immediately notify the facility of the allegation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.252: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (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.) (N/A if agency is exempt from this standard.) ☒
  Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
  ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.252: Exhaustion of administrative remedies.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Grievances/Administrative Remedy (Program Participants) Policy P-7 (*reviewed* 11/7/2018*)*
    c. Grievance/Administrative Remedy Procedure (Resident Handbook excerpt)
2. Interviews
    a. Random Residents
    b. Residents that Reported Prior Sexual Abuse
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.252(a):

During the pre-onsite portion of this audit, the Facility provided P-7: Grievances/Administrative Remedy (Program Participants) in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I establishes that "[t]he purpose of the Grievance/Administrative Remedy Program is to allow clients to seek formal review of an issue relating to any aspect of his/her program participation" (p. 1). This section continues by establishing that "Centre Inc. personnel adhere to PREA Standard 115.252 Exhaustion of administrative remedies. Director of Operations, Program Director and/or Program Manager are specifically responsible for ensuring compliance to this PREA Standard" (p. 1).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision and is not exempt from this provision as it has administrative procedures to address resident grievances regarding sexual abuse.

115.252(b):
During the pre-onsite portion of this audit, the Facility provided P-7: Grievances/Administrative Remedy (Program Participants) in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(1) establishes that "[t]he agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse" (p. 1). Section I(3) establishes, [t]he 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" (p. 2). The facility provided this auditor with a Resident Handbook. Section 5 of the Resident Handbook establishes, "[t]here is no time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. . . Residents are not required to attempt an informal resolution of any kind for alleged incidents of sexual abuse" (no page numbers). The Resident Handbook also provides a blank Resident Grievance.

During the onsite portion of this audit, this auditor observed a staff person providing a resident with a copy of the Resident Handbook. This auditor also observed the Resident Handbook to be on beds and on resident desks in resident rooms during the site review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.252(c):
During the pre-onsite portion of this audit, the Facility provided P-7: Grievances/Administrative Remedy (Program Participants) in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(c)(1)-(2) establishes, "[t]he 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" (p. 2). The Resident Handbook contains the following excerpt, "Residents are allowed to submit grievances alleging sexual abuse to a staff member who is not the subject of the complaint or incident. Centre Inc. will ensure that grievances will not be referred to the staff member who is the subject of the complaint" (no page numbers).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.252(d):
During the pre-onsite portion of this audit, the Facility provided P-7: Grievances/Administrative Remedy (Program Participants) in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(d)(1)-(3) establishes, "[t]he 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; (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 7'0 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" (p. 2). The Resident Handbook establishes, "Centre Inc. will issue a final decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance. The 90-day time period will not include time spent by the resident's administrative appeal preparation. Centre Inc. may claim an

extension of time to respond up to 70 days if the normal time period for response is insufficient to make an appropriate decision. All extension will be communicated in writing to the resident and include a date by which a decision will be made." The facility indicated that in the past 12 months, there were no grievances filed that alleged sexual abuse.

During the onsite portion of this audit, this auditor attempted to corroborate the facility's report that there had been no grievances alleging sexual abuse filed in the past 12 months by reviewing resident grievances that were filed and by interviewing randomly selected residents and asking whether they themselves or they knew of others that filed such grievances. The facility provided this auditor with a total of 18 grievances that had been filed during the past 12-month period; none of which involved a report of sexual abuse or sexual harassment. This auditor reviewed these grievances did not discover any relevant grievances to review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.252(e):
During the pre-onsite portion of this audit, the Facility provided P-7: Grievances/Administrative Remedy (Program Participants) in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(e)(1) establishes, "[t]hird 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" (p. 2). Section (I)(e)(3) establishes that if a resident declines to have third-party assistance in filing a grievance alleging sexual abuse, "the agency shall document the resident's decision" (p. 2). The facility indicated that in the past 12 months, there were no grievances filed that alleged sexual abuse.

As noted in provision (d), this auditor did not discover any relevant grievances to review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.252(f):
During the pre-onsite portion of this audit, the Facility provided P-7: Grievances/Administrative Remedy (Program Participants) in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(f)(1)-(2) establishes, "[t]he 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" (p. 2-3). The facility indicated that in the past 12 months, there were no grievances filed that alleged sexual abuse.

As noted in provision (d), this auditor did not discover any relevant grievances to review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.252(g):
During the pre-onsite portion of this audit, the Facility provided P-7: Grievances/Administrative Remedy (Program Participants) in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(g) establishes, "[t]he 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" (p. 3). The facility indicated that in the past 12 months, there were no grievances filed that alleged sexual abuse.

As noted in provision (d), this auditor did not discover any relevant grievances to review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Standard 115.253: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.253: Resident access to outside confidential support services

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019*)*
    c. An Overview for Clients on Sexual Abuse/Assault Prevention and Intervention (resident informational/Resident Handbook excerpt)
    d. Victim Advocate Contact Information Informational Posters (in English and Spanish)
    e. Photographs of Resident Informational Boards
2. Interviews
    a. Random Residents
    b. Residents that Reported Prior Sexual Abuse
3. Site Review Observations:
    a. Observations during on-site review of physical plant; review of information displayed near resident phones

Findings (By Provision):

115.253(a):

Centre has Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section II(E) of P-19 establishes that "Centre Inc. personnel adhere to PREA Standard 115.253 Resident access to outside confidential support services. Program Director and/or Program Manager are specifically responsible for ensuring compliance to this PREA Standard" (*p.* 13). Additionally, the facility has a resident information titled, "An Overview for Clients on Sexual Abuse/Assault Prevention and Intervention." This informational includes "Centre Inc. provides residents with access to outside victim advocates for emotional support services related to sexual abuse . . . Centre Inc. allows for reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible by providing all residents access to telephones" (*p.* 2). This informational further provides residents with a list of fourteen local, regional, and national treatment options that include the names, addresses, and telephone numbers of these organizations (*p.* 4–5).

During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided Policy P-19 and "An Overview for Clients on Sexual Abuse/Assault Prevention and Intervention" in support of its compliance.

During the onsite portion of this audit, this auditor interviewed 16 residents (there were no residents designated by facility staff as having reported prior sexual abuse). Out of these resident interviews, eight residents were able to inform this auditor about outside victim advocates for emotional support services related to sexual abuse. A small number of residents indicating that they knew of a number of local entities as a result of prior participation in their services while in a higher custody level but did not know how one would go about accessing them while at the present facility. The 50 percent of the residents interviewed were unable to provide any answer to questions around access to victim services that is provided by the program.

During resident interviews all residents reported that the telephones are always free and none of the phones are recorded (corroborated by facility staff). Additionally, while walking through the facility at various times, this auditor would test the phones to determine whether they had a dial tone. At every test, every phone was operational. Further, the number in the Handbook for the Rape and Abuse Crisis Center connected to that agency. While making observations during the site review, a review of PREA Notices revealed that they did not contain contact information for any outside confidential support services.

Only 50 percent of residents interviewed knew of the emotional support services available to them. Further, there is no information displayed throughout the program of the availability of these services through the Rape and Abuse Crisis Center.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.253(b):
Attachment A of Policy P-19: Sexual Abuse/Assault Prevention & Intervention includes a recitation of this standard. "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 report of abuse will be forwarded to authorities in accordance with mandatory reporting laws" (*p.* 17–18). The facility also has a resident informational titled, "An Overview for Clients on Sexual Abuse/Assault Prevention and Intervention." This informational includes, "[i]nformation concerning the identity of a client/resident victim reporting a sexual assault, and the facts of the report itself, shall be limited to those who have a need to know in order to make decisions concerning the victim's welfare and for law enforcement/investigative purposes" (*p.* 1). It further states, "Centre Inc. provides residents with access to outside victim advocates for emotional support services related to sexual abuse . . . Centre Inc. allows for reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible" (*p.* 2).

During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided Policy P-19 and "An Overview for Clients on Sexual Abuse/Assault Prevention and Intervention" in support of its compliance.

During the onsite portion of this audit, no resident was able to inform this auditor what information would remain confidential or, in the alternative, what information will be communicated back to the facility and/or other governmental entities. Additionally, when interviewing random staff, this auditor inquired as to what information, if any, would be kept confidential. The majority of staff were unable to answer that question. Additionally, both staff and residents were equally unsure whether North Dakota has promulgated mandatory reporting laws and what if any information would need to be reporting if communicated.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.253(c):

Centre Inc. maintains a memorandum of understanding (MOU) with the Rape and Abuse Crisis Center in Fargo North Dakota for "confidential emotional support services related to sexual abuse as needed." This MOU is memorialized in writing and reviewed annually between the Director of Operations/PREA Coordinator and the Director of the Rape and Abuse Crisis Center. This was demonstrated by reviewing prior MOUs provided to this auditor while onsite and through conversations with the PREA Coordinator and representative from the Rape and Abuse Crisis Center. The MOU stablishes that the Rape and Abuse Crisis Center will provide the facility with "confidential emotional support services related to sexual abuse." During the post-onsite portion of this audit, this MOU was updated to include, "The Rape and Abuse Crisis Center of Fargo, ND provides qualified agency staff members who have been screened for appropriateness to serve in their respective role(s) and have received education concerning sexual assault and forensic examination issues in general. Where necessary, the Rape and Abuse Center 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. Any Centre Inc. Residential client may discreetly contact Rape and Abuse Crisis Center directly." This update was evidence by providing this auditor with an executed MOU between both parties signed into effect on September 5, 2019.

During the onsite portion of this audit, the Director of Operations showed this auditor communications between the Rape and Abuse Crisis Center establishing their ongoing relationship (email correspondence about the need to meet and discuss any need to update the MOU), in addition to the MOU that was provided to this auditor during the pre-onsite phase of this audit. During the post-onsite portion of the auditor, this auditor was able to speak with an executive-level representative of the Rape and Abuse Crisis Center in Fargo North Dakota. This representative confirmed the existence of an MOU and relationship with Centre Inc. and disclosed that the Rape and Abuse Crisis Center has received 15 referrals from Centre Inc. facilities.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

1. Ensure staff/the facility are providing residents with information about access to outside victim advocates for emotional support services related to sexual abuse in a manner that allows for residents to retain this information or be able to know where to look in the event they wanted to access this information.

2. Develop clear information and educate residents (and staff) to what extent communications to outside support services are kept confidential.
3. Establish what, if any, mandatory reporting laws exist in North Dakota and communicate them to residents prior to giving them access to outside support services.

Final Audit Report Reassessment:
During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a) and (b) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to these provisions:
1. The Director of Operations will have Informational Posters created that will contain information about access to outside victim advocates for emotional support services related to sexual abuse. The posters will include the service's name, address and telephone numbers. The posters will include notices that convey all contact with these services can be made in a confidential manner, that telephone communications are not monitored and that any known reports of abuse will be forwarded to law enforcement in accordance with mandatory reporting laws. Information specific to North Dakota's mandatory reporting laws will also be included on these posters. Posters will be displayed throughout the facility in highly visible areas accessible to all residents, staff and visitors. Posters will be created and posted by 3-15-20.
The Auditor's proposed methodology for reassessment was to review updated informational posters and test victim services. The agreed upon timeline for completing this corrective action was March 15, 2020.

On December 31, 2019, the PREA Coordinator/Director of Operations provided the auditor with a resident informational titled, "Victim Advocate Contact Information." This poster includes the name, address (if applicable), and contact information for outside confidential support services. The poster also references applicable mandatory reporting laws and establishes that use of these services is confidential. On January 22, 2020, the Agency provided a copy of this informational poster in Spanish. On January 30, 2020, the facility provided the auditor with photographs of these information posters displayed in the entryway and centrally located in resident housing areas. On March 2, 2020, this auditor remotely tested these services by calling the Rape and Abuse Crisis Center (RACC). The auditor inquired if the operator knew of the facility and a relationship between the facility and RACC. The auditor also confirmed with the operator that the any requests for services would be kept confidential.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.254: Third party reporting.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. PREA Notice
    c. Documentation of a Third-Party Report
    d. Agency Website
2. Site Review Observations:
    a. Observations during on-site review of physical plant; review of information displayed throughout the facility

Findings (By Provision):
115.254(a):
During the pre-onsite portion of this audit, the Facility provided this auditor with a PREA Notice (evidenced to be displayed throughout the facility during the site review). This Notice establishes, "[i]f you are a victim of sexual abuse, assault, sexual misconduct, sexual harassment or staff sexual misconduct while in Centre Inc.'s Residential Program or have experienced any previously unreported abuse or harassment prior, or if you know of an incident of sexual assault of a person in the custody of any law enforcement agency, correctional facility, or in this program please report it immediately!" The Notice further establishes that "[y]ou can report it in one of the following way . . . By a Third Party." The facility indicated that the method to receive third-party reports is by writing or verbally to Centre Inc.'s PREA Coordinator or the PREA Compliance Manager at the respective facility.

The facility indicated that it distributes this information by displaying the above-mentioned Notice throughout the facility. The facility also indicated that staff review this Notice with residents upon intake. This was corroborated through confidential case file reviews. Additionally, the agency posts

this Notice on the PREA page of its website, available at: http://centreinc.org/images/PREA%20Reporting%20Notice%20to%20residents.pdf.

During the onsite portion of the audit, the facility provided this auditor with an investigative file of an allegation of staff sexual misconduct at another facility. A review of this file revealed that the initial allegation was received by way of a third-party report.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the agency provides a method to receive third-party reports and that method is publicly distributed.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.261 (a)

- Does the agency 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? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.261: Staff and agency reporting duties.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Reports of Sexual Abuse and Sexual Harassment
    d. Mandatory Reporting: Abuse and Neglect of a Vulnerable Adult Informational, developed by North Dakota Human Services
2. Interviews
    a. Director or Designee
    b. PREA Coordinator
    c. Random Staff
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.261(a):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. P-19 establishes, "[u]pon receiving an allegation that a resident was sexually abused while confined at another facility, the Director of Operations will be immediately notified. The Director of Operations will notify the facility or appropriate office of the agency where the alleged abuse occurred as soon as possible but no later than 72 hours after receiving the allegation. The Director of Operations or designee will document this notification" (p. 7). P-19 further provides that staff are required to "report . . . 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" (p. 18). The policy mandates that staff "shall act promptly to remedy . . . retaliation which includes notification to the facility's PREA Compliance Officer (or "Chain of Command" if the PREA Compliance Officer is involved)" (p. 13). The policy stresses the importance "that this information is passed along to the Director of Operations, Program Director and or Program Manager, on-call person, or designee immediately, in order to begin the investigation, and to preserve the crime scene and any potential evidence" (p. 8).

During the onsite portion of this audit, this auditor interviewed 12 staff. All staff interviewed reported that Centre Inc. requires all staff to report 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. Staff cohesively reported that the procedure for reporting any information related to a resident sexual abuse incident would be to notify your immediate supervisor and the on-call and to follow-up the verbal report with a Serious Incident Report.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.261(b):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. P-19 establishes that "[s]taff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary as specified within this policy to make treatment, investigation and other security and management decisions" (p. 8).
During the onsite portion of this audit, this auditor interviewed 12 staff. All staff interviewed that the procedure for reporting any information related to a resident sexual abuse incident would be to notify your immediate supervisor and the on-call and to follow-up the verbal report with a Serious Incident Report. Staff indicated that the priority was to make sure the resident was safe. All staff were expressed that they would notify their direct supervisor (or above that person in the event the allegation was against him/her) and would follow appropriate procedures to safeguard against disclosure of any information obtained outside of individuals necessary to make treatment, investigation, and other security and management decisions.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.261(c):
During the pre-onsite portion of this audit, the Facility indicated that they do not have any medical or mental health practitioners on staff and that residents in need of medical and mental health services are

referred to outside community-based agencies. This was verified by this auditor by review of staff rosters and human resource files.

115.261(d):
During the pre-onsite portion of this audit, the Facility indicated that they do not service anyone under the age of 18. This was verified by the auditor by reviewing the resident roster as of the first day of the audit and by interviews with the Executive Director and PREA Coordinator who also serves in the capacity as the Director of Operations. This auditor identified 2017 Senate Bill (SB) 2322 as North Dakota's mandatory reporting statute. North Dakota has a comprehensive mandatory reporting statute, Mandatory Reporting: Abuse and Neglect of a Vulnerable Adult. A review of this statute indicates that all correctional staff are included as mandatory reporters and that the statute covers any intentional or negligent act that causes harm or serious risk to any person older than age 18, or emancipated by marriage that has a substantial mental or functional impairment (2017 N.D. Senate Bill 2322).

During the onsite portion of this audit, this auditor interviewed the Facility Director, PREA Coordinator, and 12 Random Staff to review compliance in this provision. The Facility Director reported that Centre would notify the local law enforcement to investigate these matters. Centre Inc. does not house minors. The PREA Coordinator reported that all staff that work in the facility are mandatory reporters in North Dakota and that Centre Inc. would contact law enforcement and follow-up by reporting the incident to Vulnerable Adult Protective Services. Out of the 12 random staff, no staff person was able to identify that North Dakota had a specific mandatory reporting statute and what their obligation(s) were under the statute. Further, no staff was able to identify what residents in their care would fall under the protections of this statute. The facility did not provide any documentation of reports of this kind. Over the prior 12-month period, the facility reported that they had not received any allegations of sexual abuse.

Although the agency indicates that they would report any allegation to the designated State or local services, staff are not knowledgeable of the existence of this obligation and statute and do not know how that statute applies to the facility's population.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.261(e):
During the pre-onsite portion of this audit, the Facility indicated that over the past 12 months, there had been one allegation of sexual abuse or sexual harassment. The Facility provided the auditor with a forty-four-page investigative file that included the outcome of the administrative investigation, the referral to and investigative efforts of the Cass County Sheriff's Office, and a State's Attorney's Office Report Decline officially declining to prosecute this matter. A review of this investigative file revealed that this report was made by a third-party report from someone in the community that knew the resident. This report was made to the Facility Director. The Facility Director, in turn, immediately (within minutes of receiving the report) contacted the agency's investigator/PREA Coordinator.

During the onsite portion of this audit, this auditor interviewed the designated Facility Director. The Facility Director indicated that upon receiving any allegation, including from third-party and anonymous sources, staff are required to document the report immediately and follow the chain-of-command that includes contacting the Director of Operations who is the Agency's investigator.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

1. Develop and implement procedures that ensures staff report allegations when the victim is under the age of 18 or considered a vulnerable adult to the designated State or local services agency under applicable mandatory reporting laws.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (d) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. Centre Inc.'s policy PE-8 "Abuse and Neglect" outline staff's responsibility and requirement to report abuse to the appropriate Social Services agency. This policy and procedure is contained within the agency's Personnel protocols. All staff receive annual training on the Personnel Protocols and documentation of such training is maintained on file. On an annual basis, the Director of Operations will communicate an agency-wide reminder to all personnel to review this specific policy titled, "Abuse and Neglect". This reminder will be provided annually every October.
2. Centre Inc. will enhance its current training curriculum of mandatory reporting of abuse and neglect of a "Vulnerable Adult" as defined by North Dakota law.
3. Centre Inc. will train facility staff in mandatory reporting laws.

The Auditor's proposed methodology for reassessment was to review updated training curriculum and the method for which staff were trained. The agreed upon timeline for completing this corrective action was March 15, 2020.

On December 30, 2019, the PREA Coordinator/Director of Operations provided the auditor with an informational developed by North Dakota Human Services that displays what, when, what to include, and how to report allegations of abuse to applicable residents. On January 30, 2020, the facility provided me photographs of this informational displayed on the information board centrally located at the entrance of the facility. On Friday, February 7, 2020, the auditor conducted a telephone interview with the PREA Coordinator. The PREA Coordinator reported that all staff were made aware of the mandatory reporting laws during one-on-one supervision and review of the updated information board.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.262: Agency protection duties.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
2. Interviews
    a. Agency Head
    b. Director or Designee
    c. Random Staff
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.262(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. P-19 establishes that following a report that a resident has been or is at imminent risk of sexual assault, "[i]f the aggressor is known, the aggressor must be, if possible, removed from the facility and/or detained at a locked facility, pending the result of the investigation" (p. 10). Further, procedure requires that [t[he aggressor and alleged victim must be kept separate from each other. Make arrangements for physical separation of the victim and alleged aggressor in accordance with the allegations, our agreement with the referral agencies, and in accordance with law enforcement detainment policies/procedures" (p. 10). In the past 12 months, the Facility indicated that there have no occurrences where the agency or facility determined that a resident was subject to a substantial risk of imminent sexual abuse.

During the onsite portion of this audit, this auditor interviewed the Executive Director, Facility Director, and 12 randomly selected staff. The Facility Director reported that in the event that staff learned that a resident is subject to a substantial risk of imminent sexual abuse, the facility would immediately remove the aggressor from the facility. Staff unanimously reported that they would relocate the alleged victim and call that person's case manager down to assist. Staff reported their primary responsibility is to

make sure the resident felt safe. They reported that staff would be required to immediately notify the Director of Operations in order to take any steps necessary to remove the alleged aggressor. The Executive Director reported that the agency would take any steps necessary to make sure the resident was safe. After the resident was placed in a safe setting, the agency would immediately begin to investigate the claim. During the investigation, the alleged aggressor and alleged victim would be separated by Unit.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. Although no incidents were available to review, all staff interviewed knew to take whatever steps necessary to immediately act in the event that the facility learns that a resident is subject to a substantial risk of imminent sexual abuse.

Standard 115.263: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.263 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.263: Reporting to other confinement facilities.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Documentation of allegations that a resident was abused while confined at another facility.
2. Interviews
    a. Agency Head
    b. Director or Designee
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.263(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. P-19 establishes "[u]pon receiving an allegation that a resident was sexually abused while confined at another facility, the Director of Operations will be immediately notified. The Director of Operations will notify the facility or appropriate office of the agency where the alleged abuse occurred as soon as possible but no later than 72 hours after receiving the allegation" (p. 7). The facility reported that during the past 12 months, there was one allegation the facility received that a resident was abused while confined at another facility. A review of the correspondence to the facility where the sexual abuse was alleged to have occurred identified that the facility's Facility Director sent correspondence to the Facility Head at the prior facility. The correspondence provided by the Facility to support compliance is email correspondence that including an encrypted narrative detailing the resident's PREA assessment as well as the resident's actual PREA assessment.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.263(b):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. P-19 establishes "[u]pon receiving an allegation that a resident was sexually abused while confined at another facility . . . [t]he Director of Operations will notify the facility or appropriate office of the agency where the alleged abuse occurred as soon as possible but no later than 72 hours after receiving the allegation" (p. 7). The facility reported that during the past 12 months, there was one allegation the facility received that a resident was abused while confined at another facility. The facility provided email correspondence drafted by the Facility Director to the Facility Head at the prior facility. The correspondence was sent 2 days after the agency becoming aware of the prior sexual abuse. This

was demonstrated by the auditor reviewing the date indicated on the memo and PREA assessment and the date indicated on the email correspondence.

During the onsite portion of this audit, this auditor was unable to interview the staff tasked with making this report as that individual no longer works at the facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.263(c):
During the pre-audit portion of this audit, the facility reported that during the past 12 months, there was one allegation the facility received that a resident was abused while confined at another facility. The facility provided email correspondence as indicated in provision (a).

During the onsite portion of this audit, this auditor reviewed this disclosure with the staff making the report evidencing that the agency documented such notification.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. The Facility demonstrated that they documented that it has provided notification within 72 hours of receiving the allegation.

115.263(d):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. P-19 establishes, "[i[n cases where the allegation includes Centre Inc., the allegation will be investigated in accordance with this policy" (p. 7). The Facility indicated that over the past 12 months, they received two allegations of sexual abuse from other facilities. Upon this auditor requesting documentation of those two allegations, it was revealed that the two allegations were in reference to the allegations noted in subsection (a) of this standard (one for this Facility and one for another facility being audited directly after this facility).

During the onsite portion of this audit, this auditor interviewed the Executive Director of Centre, Inc. and the designated Facility Director. The Executive Director reported that the designated point of contact at Centre, Inc. is the Facility Director who would be responsible for immediately notifying the PREA Coordinator. Upon receiving an allegation, the Executive Director reported that Centre would notify the Facility Director of the facility where the alleged abuse took place and the appropriate law enforcement investigative agency, if applicable. The Executive Director reported that he was not aware of any such allegations, only receiving allegations where they had to notify other facilities. The Facility Director reported that the agency would be responsible for immediately investigating the allegation in accordance with policy. The Facility Director reported that there are no examples of another facility or agency reporting allegations occurring while a resident was residing at a Centre facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.264: Staff first responder duties.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
2. Interviews
    a. Security Staff and Non-security Staff First Responders
    b. Residents who Reported a Sexual Abuse
    c. Random Staff
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.264(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. P-19 establishes first responder policy and procedures for allegations of sexual abuse, titled: "Investigations of recent non-consensual sexual acts (occurring within 72 hours)/First Responder duties" (p. 9). P-19 establishes: [i]f the alleged aggressor is known, the aggressor must be, if possible, removed from the facility and/or detained at a locked facility" (p. 10). P-19 further establishes that "[i]f it is determined that evidence may still exist, or that a crime has been committed, secure the potential crime scene. Any potential evidence should remain in place for law enforcement examination and investigation" (p. 9). P-19 requires, "[i] f 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" (p. 9). And lastly, P-19 establishes that [i]f the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The Facility reported that during the past 12 months there were no instances where staff were notified within a time period that still allowed for the collection of physical evidence. A review of the Facility's sexual abuse allegations over the past 12-month period, revealed that there was only one allegation made and that was an allegation made through a third-party report after the resident had discharged from the program.

During the onsite portion of this audit, this auditor interviewed security and non-security staff. There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered. In this facility, all direct care staff disclosed they were first responders. The direct care workers at this Facility are titled Residential Specialists. As a result, four Residential Specialists interviewed were asked the first responder protocol. All staff interviewed reported that as a first responder it was their responsibility to separate the alleged victim and abuser, secure the scene and call local law enforcement so they can collect any evidence that may be discoverable, not allow either the alleged abuser or alleged victim take any actions that could destroy physical evidence, and immediately calling local law enforcement and an ambulance, and offering mental health services. It should be noted that this auditor asked these questions in an open-ended fashion and staff informed this auditor of the procedures.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.264(b):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. P-19 establishes "[i]f 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 . . . [and] remain with the client to provide support and to ensure that the victim does not wash, shower, or change clothes prior to the examination; inform the on-duty supervisor and on-call person of the alleged assault" (p. 9). The Facility reported that during the past 12 months there were no instances where the first staff responder was not a security staff member. A review of the Facility's sexual abuse allegations over the past 12-month period, revealed that there was only one allegation made and that was an allegation made through a third-party report after the resident had discharged from the program.

During the onsite portion of this audit, this auditor interviewed four non-security staff first responders and 12 staff utilizing the random staff protocol. All staff interviewed reported that their responsibility was to remain with the alleged victim and make sure that the alleged victim does not take any actions that could destroy physical evidence. Staff reported they are also required to notify the on-duty supervisor of the allegation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.265: Coordinated response.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Program Informational: "Centre Inc. Coordinated Response to PREA Incidents"
    c. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
2. Interviews
    a. Facility Director of Designee
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.265(a):

During the pre-onsite portion of this audit, the Facility provided a flow chart detailing "Centre Inc. Coordinated Response to PREA Incidents." This flow chart establishes program expectations starting with the first responder and continues by establishing expectations of the Residential Specialist/On-call, medical and behavioral health staff brought in, investigative staff, and the roles of the PREA Compliance Manager and PREA Coordinator. This response plan is used in conjunction with Policy P-19: Sexual Abuse/Assault Prevention & Intervention, which establishes staff expectations in greater detail (as referenced in section 115.263).

During the onsite portion of this audit, this auditor observed the "Coordinated Response to PREA Incidents" displayed in the control room in both the North and South Units. Additionally, this auditor observed policy and procedure manuals at each station within the control booth for reference by staff. This auditor interviewed the Facility Director. The Facility Director indicated that the facility has a coordinate response and referenced the aforementioned plan. This person then described the coordinated response plan; the expectation of staff is the first responder in the situation makes sure that the alleged victim does not take any action to destroy any physical evidence (showering, laundering clothes, brushing teeth, smoking, etc.). Then the crime scene is preserved with staff and residents not being allowed into the area until law enforcement arrives. Then only law enforcement and the investigators are allowed. A record will be kept of all persons entering the crime scene, and the time they entered. The area will remain secured as a crime scene until the law enforcement investigator releases it. They then inform the on-duty supervisor and on-call personnel of the alleged abuse. The first responder documents all information as it was reported to them. The on-call personnel notifies the Director of Operations and the Executive Director. Staff then escort the victim to a medical facility for examination and a referral to a mental health department is done.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.266: Preservation of ability to protect residents from contact with abusers.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
2. Interviews
    a. Agency Head
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):
115.266(a):
During the pre-onsite portion of this audit, the agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since the last PREA audit.

During the onsite portion of this audit, this auditor interviewed the Executive Director of Centre, Inc. The Executive Director reported that no collective bargaining agreements have been entered into or renewed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.266(b): The auditor is not required to audit this provision.

Standard 115.267: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.267: Agency protection against retaliation.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Whistleblower Protection Policy PE-44 (*reviewed* 8/20/2018)
    d. Retaliation Monitoring Data Sheet
    e. Documentation of any protective measures taken
2. Interviews
    a. Agency Head
    b. Facility Director of Designee
    c. Designated Staff Member Charged with Monitoring Retaliation
    d. Residents who Reported a Sexual Abuse
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.267(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(D)(8)(f) establishes, "[e]mployees are prohibited from any form of retaliation against a client who makes an allegation of staff sexual misconduct or staff sexual harassment" (p. 12). Section I(F) further establishes, "[r]etaliation of any kind against any person (residents, staff, volunteers, visitors etc.) will not be tolerated. Residential programs will have a designated staff person on every shift (24 hours per day, 365 days per year) who is assigned the duty of monitoring for retaliation. When staffing patterns allow for one staff person on shift, this person, regardless of title, will be assigned this duty. When staffing patterns allow for more than one person on shift, the Residential Specialist II will have this responsibility" (p. 13). The Facility also provided policy PE-44: Whistleblower Protection. Section II(6) establishes, "[a]nyone who retaliates against the Whistleblower (who reported an event in good faith) will be subject to discipline, including termination of Board or employee status" (p. 2). The Facility reported that Residential Specialists and Program Managers supervise retaliation within the facility.

A review of this policy reveals that the Agency has established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation. Further the Agency has designated Residential Specialists and Program Managers as the staff members charged with monitoring retaliation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.267(b):

During the onsite portion of this audit, this auditor interviewed the Agency Head, Facility Director, the staff member charged with monitoring retaliation, and residents who reported a sexual abuse to make a compliance determination of this provision.

The Executive Director of Centre, Inc. reported that depending on the circumstances surrounding the report, Centre would consider changing room assignments, transfer or removal of the alleged abuser from the facility and/or to the opposite Unit, and Centre would offer emotional support services through a local community-based agency. The Facility Director informed this auditor that if there was an immediate threat of retaliation, the accused would be removed from the facility immediately until the investigation is completed. For all other instances, action plans will be developed by the Program Manager to ensure the reporter is free from retaliation. The Facility Director reported that such measures include: housing changes or transfers, removal of abusers, make a referral for counseling or emotional support services. The Director further established that a plan will be developed for retaliation; if it were immediate, the accused would be removed from the facility until investigation is complete. In the event the retaliation involved staff, the facility would change staff schedules to prevent interaction between the staff person and resident (or staff persons). This auditor also interviewed a designated staff member charged with monitoring retaliation. This staff person reported that in the event there was a report, the facility would make sure the reporting party felt safe. This person would be offered emotional support services to that individual. In the event that the reporting party was a staff person, they would include the Director of Operations as a party to create an action plan to ensure that the staff person was free from retaliation from other staff or residents. The retaliation monitor reported that having two completely separate units allows for the easy transfer or removal of the alleged staff or resident abusers from contact with the victim or those cooperating.

There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered. A review of the one allegation of sexual misconduct received by the Agency over the past 12 months revealed that the alleged victim of the allegation had already discharged from that facility prior to the report being made. As a result, there were no persons present in the facility (or the male facility) to monitor for retaliation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the Agency Head, Facility Director, and staff person charged with the monitoring of retaliation all reported that the agency would employ multiple protection measures, including housing unit changes, removal, and offering of emotional support services for both residents and staff.

115.267(c):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section I(F) establishes, “[t]he assigned and designated on-shift staff person will monitor the conduct and treatment of residents or staff who have reported sexual abuse and of residents or staff 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 which includes notification to the facility’s PREA Compliance Officer (or “Chain of Command” if the PREA Compliance Officer is involved)” (p. 13). Section (F) further establishes, “[t]he frequency of status checks will be determined on a case by case situation and designed to safeguard the individual’s safety and consider and minimize the individual’s potential anxiety . . . The assigned and designated staff will be cognizant of resident disciplinary reports, housing, and program changes and will immediately report anomalies to the

PREA Compliance Officer and or "Chain of Command." The PREA Coordinator will monitor and investigate negative performance reviews or reassignments of staff involving personnel involved in potential retaliation situations" (p. 13). Section (F) also establishes the "[i]nitial retaliation monitoring period begins at the time abuse occurred or time report of abuse was made. The initial retaliation monitoring period will last 90 days. The monitoring period will be extended if the need exists" (p. 13). The Facility reported that there have been no times an incident of retaliation occurred in the past 12 months.

During the onsite portion of this audit, this auditor interviewed the Facility Director and staff charged with monitoring retaliation. The Facility Director reported that in the event that the facility suspected retaliation against an alleged victim or person cooperating with an investigation, they would immediately notify the PREA Compliance Manager and PREA Coordinator/Director of Operations. This person reported that the facility would then employ the protective measures discussed in provision (b) of this standard. The staff person interviewed that is charged with monitoring retaliation reported that they would completed a Monitoring Sheet that included, checking-in with staff about any possible change of behaviors that the target is exhibiting, any increase in discipline reports or negative performance, any resident requests to change rooms or assignments, and any excessive call-outs by staff. This person reported that they would check-in with the individual weekly throughout the first four-to-six weeks then evaluate the frequency needed thereafter; that this observation would continue for 90 days and would be extended indefinitely, if the need arose.

The Facility reported that there have been no times an incident of retaliation occurred in the past 12 months. This auditor attempted to verify that report by reviewing the facility's retaliation log and prior allegations of sexual abuse or sexual harassment received in the past 12 months. A review of those documents revealed that there were no instances of retaliation in the past 12 months. The facility did provide this auditor with a monitoring sheet titled: "Retaliation Monitoring Data Sheet (Substantiated/Unsubstantiated Sexual Abuse and Sexual Harassment)." This form includes basic information regarding the target, the date monitoring began, the 90-day expiration, and whether the monitoring is new or an extension of a prior 90-day period. Additionally, the form requires a review of disciplinary reports, housing changes, programmatic changes, performance evaluations, staff reassignments, and face-to-face check-ins.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.267(d):
During the onsite portion of this audit, this auditor interviewed staff charged with monitoring retaliation. The staff person interviewed that is charged with monitoring retaliation reported that they would conduct weekly status checks of the target that included a face-to-face check-in and review of disciplinary reports, housing changes, programmatic changes, performance evaluations, staff reassignments, and face-to-face check-ins. These status checks would continue weekly for the first four-to-six weeks and would continue thereafter at the determined interval (and as needed) for the duration of the 90-day period of monitoring, or as extended. As discussed in subsection (c) of this standard, the facility reported and this auditor reviewed that there has not been an incident of retaliation that occurred in the past 12 months, nor was there any monitoring needing to conducted as a result of an allegation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.267(e):
During the onsite portion of this audit, this auditor interviewed the Executive Director of Centre, Inc. and the staff charged with monitoring retaliation. The Executive Director reported that if any other individual who cooperated with an investigation expressed a fear of retaliation, the agency would take any reasonable measure possible to ensure that person is safe. The Exec. Dir. informed this auditor for employees, Centre has established a whistleblower policy, and for residents, Centre would consider restrictions, room assignment changes, and the transfer or removal of the perpetrator. The Facility Director reported that any fear of retaliation, regardless of who reported it, would be reported to the PREA Compliance Manager and PREA Coordinator and be will be protected and monitored as described in subsections (b) and (c) of this standard.

The Facility reported that there have been no times an incident of retaliation occurred in the past 12 months. This auditor attempted to verify that report by reviewing the facility's retaliation log and prior allegations of sexual abuse or sexual harassment received in the past 12 months. A review of those documents revealed that no other individual who cooperated with the investigation reported fear of retaliation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.267(f): The auditor is not required to audit this provision.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.271: Criminal and administrative agency investigations

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Investigative records/reports for allegations of sexual abuse or sexual harassment
    b. Criminal investigation reports
    c. Administrative investigation reports

2. Interviews
    a. Investigative Staff
    b. Residents who Reported a Sexual Abuse
    c. PREA Coordinator
    d. Director, or Designee
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.271(a):
Centre has Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section II(D) of P-19 establishes the protocols for "Investigations of Non-Consensual Sexual Acts, Abusive Sexual Contacts, Client Sexual Harassment, Staff Sexual Misconduct, or Staff Sexual Harassment" (*p.* 8). Centre has documented procedures establishing that all allegations of sexual abuse and sexual harassment are investigated promptly, thoroughly, and objectively (*p.* 8–13).

The Agency indicated that over the past 12 months, there had been one allegation resulting in an administrative investigation; this same investigation resulted in referral for criminal investigation and prosecution. The Facility provided the auditor with a forty-four-page investigative file that included the outcome of the administrative investigation, the referral to and investigative efforts of the Cass County Sheriff's Office, and a State's Attorney's Office Report Decline officially declining to prosecute this matter. Documentation revealed that this allegation was received by way of a third-party report and the staff person receiving the allegation reported the allegation to the agency's PREA Coordinator/Director of Operations within fifteen minutes of initially receiving the third-party report. The investigation resulted in the staff person resigning the same day as the report in lieu of responding to the agency investigator's attempts to schedule a meeting. The agency assisted the Cass County Sheriff's Department, Fargo Police Department, and North Dakota Department of Corrections and Rehabilitation during their criminal investigation into this allegation. Ultimately, the State's Attorney's Office officially declined to prosecute the matter.

The auditor was able to analyze the evidence reviewed in the administrative investigation to determine whether the agency investigated the allegation promptly, thoroughly, and objectively. Thoroughly means all potential evidence is collected and considered, including but not limited to: physical evidence, documentary evidence, video evidence, telephone records and recordings. Objectively means an investigation is conducted by an investigator without any bias or presumption. Promptly means within a reasonable amount of time to assure that evidence, including information from witnesses, victims and subjects is not lost or forgotten when allegations of sexual contact are made where a forensic medical exam is in order, the investigation starts immediately so as not to lose that evidence. The investigation into this allegation was evidenced to begin within 15 minutes of the initial report being made by the third-party reporter. The investigator was evidenced to collect all potential evidence that this person had access to, including but not limited to: cell phone pictures, interviewing of potential witnesses, obtaining a cell phone bill, and email correspondence. Lastly, the report provided indicated that the investigating staff investigated without bias or presumption and followed the evidence that was obtained; ultimately substantiating the allegation and referring the matter for a criminal investigation through the Cass County Sheriff's Department and Fargo Police Department.

During the on-site portion of this audit, this auditor interviewed the agency's investigator – also serves as the agency's PREA Coordinator. The PREA Coordinator revealed that the investigation begins immediately upon PREA Compliance Officer and PREA Coordinator receiving the report and after obtaining the client's referral source oversight personnel's authorization to begin. The investigator further stated that third-party reports are handled in the same way and are not investigated differently.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(b):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided training certificates of key personnel that serve as investigators in the agency (one of these staff people had since reigned from their post shortly after initiation of this audit).

During the onsite portion of this audit, this auditor interviewed the Agency's investigator/PREA Coordinator. The special training in sexual abuse investigations this staff person has received is the following:1) "The National PREA Standards: Implications for Human Resource Practices in Correctional Settings" sponsored by the National PREA Resource Center - training included a module titled, "Investigation"; 2) 3 hour on-line training titled, "PREA: Investigating Sexual Abuse in a Confinement Setting" presented by the National Institute of Corrections; 3) a 20-hour PREA Investigator training provided by the "Moss Group" and hosted by the North Dakota Department of Corrections and Rehabilitation; and a 2-day training titled, "Investigating Sexual Misconduct: Training for Correctional Investigators" facilitated by the North Dakota Department of Corrections and Rehabilitation. The auditor reviewed training records/certificates evidencing completion of these trainings. The investigative staff indicated the 2-day training titled, "Investigating Sexual Misconduct: Training for Correctional Investigators" facilitated by the North Dakota Department of Corrections and Rehabilitation covered 1) techniques for interviewing sexual abuse victims; 2) proper use of Miranda and Garrity warnings; 3) Sexual abuse evidence collection in confinement settings; and 4) criteria and evidence required to substantiate a case for administrative action or prosecution referral as required by standard 115.234.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(c):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided the above-referenced investigative file as evidence of their compliance.

During the onsite portion of this audit, this auditor interviewed the Agency's investigator/PREA Coordinator. The investigator informed the auditor that in the event of an allegation the first steps in initiating an investigation are: the PREA Coordinator would assign a Sexual Abuse Response Team (SART) and assign a lead investigator (typically the PREA Coordinator / Director of Operations) who has received the specialized training. This would occur immediately upon receiving the report. The assigned investigator would be responsible for gathering and preserving direct and circumstantial evidence, begin interviewing alleged victims, suspected perpetrators, any electronic monitoring or other electrically stored evidence, and witnesses. During the interview, the PREA Coordinator reviewed that on the investigation reported in the PAQ, the investigator safeguarded pictures obtained on the alleged victims cell phone,

cell phone bills including detailed call list obtained by a third-party witness, and reduced witness statements to writing. In cases where circumstantial evidence exists and it is believed that a crime has potentially occurred, Centre Inc. personnel would be responsible for safeguarding it and not disturbing it nor "gathering" it. This task would be law enforcement's responsibility.

The investigative file provided by the agency during the pre-onsite portion of this audit evidenced the creation of the SART and documentation of efforts the investigator took during the investigation to include interviewing and attempts to interview potential witnesses, the victim, and the alleged perpetrator. It further evidences contacts made to law enforcement agencies, in addition to a reciprocal disclosure (and retention of) investigative efforts/contacts by that agency. In addition, it contained a referral to the State's Attorney's Office and a synopsis of the resolution of the investigation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(d):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided the above-referenced investigative file as evidence of their compliance.

During the onsite portion of this audit, this auditor interviewed the Agency's investigator/PREA Coordinator. The investigator informed the auditor that in the event the program discovers evidence that a prosecutable crime may have taken place, the investigator would not conduct compelled interviews as these matters would be immediately referred to law enforcement who would be responsible for the criminal investigation and prosecutor consultation.

In review of the investigative file provided by the Agency, the chronological log detailing investigative steps evidences that agency investigators did not conduct any compelled interviews and the matter was referred to local law enforcement the same day the allegation was received.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(e):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided the above-referenced investigative file as evidence of their compliance.

During the onsite portion of this audit, this auditor interviewed the Agency's investigator/PREA Coordinator. The investigator informed this auditor that the judging the credibility of an alleged victim, suspect, or witness is done in an individual basis and is assessed objectively without a presumption that one person is more credible that another until the assessment of credibility shows one way or another. The investigator further provided that under no circumstances would a resident who alleges sexual abuse be required to a polygraph examination or truth-telling device as a condition for proceeding with an investigation.

There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and

staff interviews. No residents who reported a sexual abuse were discovered. As a result, this auditor was unable to question any resident who reported prior sexual abuse in this facility to inquire whether or not the resident would be/had been required to take a polygraph test as a condition for the facility proceeding with a sexual abuse investigation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(f):
During the onsite portion of this audit, this auditor interviewed the Agency's investigator/PREA Coordinator. The investigator informed this auditor that administrative investigations do include an effort to determine whether staff actions or failures to act contributed to the abuse. The investigator further established that during interviews and evidence gathering looking they actively look for the existence of staff neglect, violation of the standards of employee conduct, and whether staff maintained fidelity with the agency's policies and procedures. Additionally, the investigator reported that all administrative investigations are documented in written reports that include: a description of all physical and testimonial evidence; all questions asked of these people; a list of and responses of all witnesses, staff, or community-service providers interviews; follow-up with law enforcement as well as notification to the alleged victim; and findings along with evidence used to make the determination of substantiated, unsubstantiated, or unfounded.

During the pre-onsite portion of this audit, the Agency indicated that over the past 12 months, there had been one allegation of sexual harassment resulting in an administrative investigation. The Facility provided the auditor with a forty-four-page investigative file that tracked the efforts of staff upon initially receiving the allegation through the administrative investigatory efforts and substantiation and referral to the Cass County Sheriff's Department in collaboration with the Fargo Police Department for criminal investigation. Ultimately, the State's Attorney's Office officially declined to prosecute the matter. The above-mentioned packet contained a written report that included a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Additionally, it contained a form, titled: "Sexual Abuse Response Team (SART) Report" that contained evaluation of whether staff actions or failures to act contributed to the abuse and whether staffing was adequate to protect the resident from abuse.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(g):
During the onsite portion of this audit, this auditor interviewed the Agency's investigator/PREA Coordinator. The investigator informed this auditor that criminal investigations (similar to administrative investigations) are documented and retained pursuant to the Agency's record retention policy. The investigator disclosed that the local law enforcement agency provides the agency with a detailed account of all efforts completed during the investigation, including the date and time and person that completed the task. The investigator further communicated that the information includes a thorough description of any evidence obtained.

A review of the investigative file provided by the facility evidencing the only referral for criminal investigation revealed that the Sacco County Sheriff's Department provided routine information back to the facility as to their progress with the investigation. The information reported back to the facility included: personnel assigned to the investigation, details of efforts made and by whom, witness accounts and other evidence obtained, the application and execution of a search warrant, application for criminal complaint, description and custody of evidence, and who this information was being distributed to.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(h):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided Policy P-19: Sexual Abuse/Assault Prevention & Intervention as evidence of their compliance. Policy P-19 establishes that "[a]n investigation is conducted and documented whenever a sexual assault or threat is reported . . . [upon receiving an allegation staff shall] notify the local law enforcement agency having jurisdiction of the allegations and confirm their plan for investigation including time line(s)." (*p.* 8–9). Section D(7) further establishes that upon receipt of an allegation of sexual harassment, "[i]f after the initial interview with the victim . . . if the staff person suspects a crime may have been committed, the staff person will notify the local law enforcement agency having jurisdiction." (*p.* 11).

During the pre-onsite portion of this audit, the Agency indicated that over the past 12 months, there had been one allegation being referred for criminal investigation. The Facility provided the auditor with a forty-four-page investigative file that tracked the efforts of staff upon initially receiving the allegation through the administrative investigatory efforts and substantiation and referral to the Cass County Sheriff's Department in collaboration with the Fargo Police Department for criminal investigation. The packet also evidenced the fact that the substantiated allegation was referred to the State's Attorney's Office for prosecution. Ultimately, the State's Attorney's Office officially declined to prosecute the matter, which was evidenced by a letter from the prosecutor retained by the facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(i):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided Policy P-19: Sexual Abuse/Assault Prevention & Intervention as evidence of their compliance. Section II(I)(1) establishes that "[a]ll case records associated with claims of sexual abuse, including incident reports, investigative reports, client information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and or counseling will be retained in accordance with Centre's record retention policy" (*p.* 14).

During the onsite portion of this audit, this auditor requested administrative policies. The agency provided me with Policy SP-6: "Information Practices, Records, Retention and Data: Statistics, Outcome Measures and Agency Cooperation." Section II(C) of SP-6 establishes that "[a]ll investigation files specific to PREA involving clients will be retained for five (5) years after the last date of program involvement" (*p.* 6). Additionally, SP-6 establishes that "[a]ll investigation files specific to PREA involving personnel will be retained for five (5) years after the last date of employment" (*p.* 6).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.271(j):
During the onsite portion of this audit, this auditor interviewed the Agency's investigator/PREA Coordinator. The investigator informed this auditor that the departure of the alleged abuser or victim from the employment or control of the facility or agency does not terminate the investigation pending. The investigator informed this auditor that efforts would be continued to complete the investigation.

During the pre-onsite portion of this audit, the Agency indicated that over the past 12 months, there had been one allegation resulting in an administrative investigation that was ultimately referred to the local law enforcement for criminal investigation/prosecution. This report was obtained by the facility after this particular resident had released (and was residing at home). The investigation packet evidenced that despite the alleged victim no longer being under the control of the facility, the investigation continued.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.271(k): Auditor is not required to audit this provision.

115.271(l):
During the onsite portion of this audit, this auditor interviewed the Agency's investigator, PREA Coordinator, and facility leadership. Prior to the start of the onsite portion of this audit, the agency revealed to this auditor that the facility director position had recently become vacant. As a result, this auditor interviewed the staff person designated as acting in that capacity as well as facility high-level supervisory personnel utilizing the facility director protocols. The PREA Coordinator informed this auditor that Centre informs the investigating agency of the PREA standard that requires that the facility remain informed of the progress and outcome of the investigation. Additionally, facility high-level supervisory personnel revealed that in the event the Centre does not conduct the investigation, the facility requests relevant information from the investigative agency in order to jeep the resident and referral source informed. Lastly, this auditor interviewed the agency investigator. The investigated identified that both himself as well as facility staff will perform any task within their authority and job description that the law enforcement agency requests of them; typically, however, this would only involve the collection of records within the program as any investigatory work (e.g., interviews) would be performed by local law enforcement once they are involved.

A review of the investigative file provided by the facility evidencing the only referral for criminal investigation revealed that the Sacco County Sheriff's Department provided routine information back to the facility as to their progress with the investigation. The information reported back to the facility included: personnel assigned to the investigation, details of efforts made and by whom, witness accounts and other evidence obtained, the application and execution of a search warrant, application for criminal complaint, description and custody of evidence, and who this information was being distributed to.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision

Standard 115.272: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.272: Evidentiary standard for administrative investigations.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Investigative records/reports for allegations of sexual abuse or sexual harassment
    d. Criminal investigation reports
2. Interviews
    a. Investigative Staff

Findings (By Provision):
115.272(a):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(C) of this policy establishes that "[s]ubstantiated allegation means an allegation that was investigated and determined to have occurred . . . [u]nsubstantiated allegation means an allegation that was investigated and determined not to have occurred" (p. 4). The Facility indicated that over the past 12 months, there had been one allegation resulting in an administrative investigation; this same investigation resulted in referral for

criminal investigation and prosecution. The Facility provided the auditor with a forty-four-page investigative file that included the outcome of the administrative investigation, the referral to and investigative efforts of the Cass County Sheriff's Office, and a State's Attorney's Office Report Decline officially declining to prosecute this matter. In the administrative investigation section of this packet, the facility completed a form titled, "Notice of Prison Rape Elimination Act (PREA) Investigation Status." This form was completed on September 25, 2018 and indicated the outcome of the allegation of sexual harassment was "substantiated" and that the staff person was "no longer employed at the facility [and had] been included as a suspect in the case, which was presented for prosecution to local authorities."

During the onsite portion of this audit, this auditor interviewed the Agency's primary investigator. The investigator informed this auditor that the standard of evidence required to substantiate allegations of sexual abuse or sexual harassment was preponderance of evidence. This staff person brought an excerpt from a 20-hour PREA investigator training provided by The Moss Group, Inc. that defined various key concepts, including: preponderance of evidence, beyond a reasonable doubt, and *Miranda* and *Garrity* warnings. The investigator further informed this auditor that the preponderance of evidence standard was used in deciding to substantiate the allegation provided.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. Despite the policy not defining what standard of evidence is required to substantiate allegations of sexual abuse or sexual harassment, the Agency's investigator has been trained in these concepts and informed this writer the appropriate evidentiary burden when investigating an allegation.

Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the

resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.273: Reporting to residents.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Investigative records/reports for allegations of sexual abuse or sexual harassment
    d. Criminal investigation reports
    e. Resident Notification
2. Interviews
    a. Investigative Staff
    b. Director or Designee
    c. Residents who Reported a Sexual Abuse

Findings (By Provision):

115.273(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes, "[f]ollowing 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" (p. 18).

The agency indicated that over the past 12 months, there had been one allegation resulting in an administrative investigation; this same investigation resulted in referral for criminal investigation and prosecution. The initial report was behaviors that were sexually harassing in nature (sending illicit photographs to a resident). During the investigation, allegations of sexual misconduct were revealed and resulted in referral local law enforcement for investigation. The facility provided this auditor with a document titled, "Notice of Prison Rape Elimination Act Investigation Status" signed by the former resident that indicated that the sexual harassment allegation had been substantiated and that the alleged staff member was no longer employed at the facility and had been included as a suspect a criminal case presented to local authorities.

During the onsite portion of the audit, this auditor interviewed the Program Director. The Director indicated that following an investigation, Centre informs the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The Program Manager documents this follow up in a serious incident report. There were no residents who reported a sexual abuse while this auditor was at the facility available to be interviewed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.273(b):

During the pre-onsite portion of this audit, the Facility provided this auditor with a copy of the Cass County Sheriff's Department Case Report and State's Attorney's Office Report Decline in addition to the aforementioned "Notice of Prison Rape Elimination Act Investigation Status" in support of their compliance in this standard (*see* provision (a)). The Cass County Sheriff's Department Case Report

details all investigative efforts conducted and the outcome of that investigation. Additionally, the Case Decline Report provides a recitation of law and application of applicable criminal law to the facts presented by the Sheriff's Department. Both of these items were evidenced to be included the resident notification. This was the only applicable investigation reported by the facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.273(c):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes, "[f]ollowing 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" (p. 18). As indicated above, the facility indicated that there had been one substantiated complaint of sexual abuse committed by a staff member against a resident in an agency facility in the past 12 months. The facility indicated that this resident was no longer a resident at a Centre, Inc. facility when the allegation was made, but they still informed him of the outcome.

The facility provided this auditor with a document titled, "Notice of Prison Rape Elimination Act Investigation Status" signed by the former resident that indicated that the sexual harassment allegation had been substantiated and that the alleged staff member was no longer employed at the facility and had been included as a suspect a criminal case presented to local authorities. As indicated in provision (a) of this standard, there were no residents who reported a sexual abuse while this auditor was at the facility available to be interviewed

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.273(d):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes, "[f]ollowing 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.

The facility reported that there were no instances of resident-on-resident abuse in the facility to review. This auditor attempted to corroborate that report during interviews with random staff and while reviewing resident confidential case files.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.273(e):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Attachment A establishes, "[a]ll [pertinent] notifications or attempted notifications shall be documented" (p. 19).

As reviewed in provisions (a) through (c) of this standard, the facility provided this auditor with documentation evidencing that the only notification made pursuant to this standard was documented.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.273(f): the Auditor is not required to audit this provision.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.276: Disciplinary sanctions for staff.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Investigative file including documentation of resignation and notification of law enforcement.
    d. Resident Grievances
2. Interviews
    a. PREA Coordinator
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.276(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section II(D)(8)(h) establishes, "[e]mployees, contract volunteers, official visitors, or agency representatives who are found to have committed staff sexual misconduct as defined above will face internal discipline, and the facility will also work with law enforcement to aid in the prosecution of such charges to the fullest extent possible. Employees, contract volunteers, official visitors, or agency representatives who are found to have committed staff sexual harassment will be disciplined internally per Centre's personnel policies. Centre Inc. will report all relevant information specific to employee, volunteer, official visitor, or agency representative discipline to relevant licensing bodies. The facility's PREA Compliance Officer is responsible for documenting this notification" (p. 11).

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that any staff that violated the agency sexual abuse or sexual harassment policy (as well as the Employee Standards of Conduct) would be subject to disciplinary sanctions up to and including termination.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.276(b):

During the pre-onsite portion of this audit, the Facility indicated that there had been no staff from the facility who had violated the agency's sexual abuse or sexual harassment policies. However, the facility reported that in the past 12 months, there had been one staff from the male facility who had violated the agency's sexual abuse or sexual harassment policies and provided documentation to evidence the facility's established protocols in the event this occurs in the facility. This staff person was suspended during the pendency of the administrative investigation and resigned prior to her termination. This was evidenced by a review of the investigative file of this incident provided by the facility. This packet included Attachment A that indicated that upon being suspended pending an investigation she resigned (on June 8, 2018).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.276(c):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section II(D)(8)(h) establishes, "[e]mployees, contract volunteers, official visitors, or agency representatives who are found to have committed staff sexual harassment will be disciplined internally per Centre's personnel policies" (p. 11). The facility reported that over the past 12 months there have been no staff from the facility who have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse). This auditor corroborated that through review of resident grievances filed over the past 12 months.

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that any staff that violated the agency sexual harassment policy (as well as the Employee Standards of Conduct) would be subject to commensurate disciplinary sanctions with input from the agency's contracting bodies. The PREA Coordinator confirmed that there had been no disciplinary action taken on staff who had been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.276(d):
During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section II(D)(8)(h) establishes, "Centre Inc. will report all relevant information specific to employee, volunteer, official visitor, or agency representative discipline to relevant licensing bodies. The facility's PREA Compliance Officer is responsible for documenting this notification" (p. 11). The Facility indicated that in the past 12 months, there had been one staff from the male facility who had been reported to law enforcement or licensing boards following their termination for violating the agency's sexual abuse or sexual harassment policies.

This was evidenced by a review of the investigative file of this incident provided by the facility. This packet included a Cass County Sheriff's Department Case Report that detailed the notification made by the facility and subsequent criminal investigation that took place.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Standard 115.277: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.277: Corrective action for contractors and volunteers.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Resident Grievances
2. Interviews
    a. Facility Director of Designee
    b. PREA Coordinator
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.277(a):

During the pre-onsite portion of this audit, the Facility provided P-19: Sexual Abuse/Assault Prevention & Intervention in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section II(D)(8)(h) establishes, "contract volunteers . . . who are found to have committed staff sexual misconduct as defined above will face internal discipline, and the facility will also work with law enforcement to aid in the prosecution of such charges to the fullest extent possible. Employees, contract volunteers, official visitors, or agency representatives who are found to have committed staff sexual harassment will be disciplined internally per Centre's personnel policies. Centre Inc. will report all relevant information specific to employee, volunteer, official visitor, or agency representative discipline to relevant licensing bodies. The facility's PREA Compliance Officer is responsible for documenting this notification" (p. 11). The facility indicated that over the past 12 months, there had been no instances where contactors or volunteers had been reported to law enforcement agencies or relevant licensing bodies for engaging in sexual abuse of residents.

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that any contractor or volunteer who engages in sexual abuse would be barred from the facility permanently. The PREA Coordinator confirmed that there had been no instances where contactors or volunteers had been reported to law enforcement agencies or relevant licensing bodies for engaging in sexual abuse of residents.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.277(b):
During the pre-onsite portion of this audit, the Facility indicated that this had never occurred.

During the onsite portion of the audit, this auditor interviewed the Facility Director. The Facility Director reported that if a contractor or volunteer is found to have committed misconduct, the facility would call law enforcement and aid in the investigation and prosecution. The contractor or volunteer would not have access to the resident and would not be allowed at the facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Standard 115.278: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.278 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.278: Disciplinary sanctions for residents.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Resident Rules and Discipline Policy P-14 (*reviewed* 11/30/2018)
    c. Resident Rules and Discipline Policy P-14 (*effective* 3/18/2020)
    d. Resident Handbook, Appendix A
    e. Bureau of Prison's Prohibited Acts
2. Interviews
    a. Facility Director of Designee
    b. PREA Coordinator
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.278(a):

During the pre-onsite portion of this audit, the Facility provided P-14: Program Rules & Discipline in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section II(A) and Section II(B) establish the formal disciplinary processes Federal Bureau of Prisons residents and North Dakota Department of Corrections and Rehabilitation residents (p. 10-11). The Facility also provided this auditor with a form titled, "Centre Residential Services Contract." This form is taken from Section 1 of the Resident Handbook (as evidenced by reviewing Resident Handbooks while onsite and post-onsite). This Section defines the formal disciplinary process for residents: "[t]he Formal Disciplinary Hearing is held. The resident is entitled to be present at the formal hearing except during deliberations of the decision maker(s). The resident is entitled to make a statement and to present documentary evidence on their own behalf. The hearing committee and/or officer will consider all evidence presented at the hearing and will make a decision based on facts and based on the greater weight of the evidence" (p. 10). The Residential Services Contract details a list of facility rules and prohibited behaviors, including sexual abuse (p. 10). P-14 establishes that "a formal disciplinary hearing [will be conducted] for resolution of these rule infractions and sanctioning" (p. 3). The Residential Contract further establishes that "[v]iolation of any federal or state law (felony or misdemeanor offenses)" will result in the formal disciplinary process (p. 12). The Facility indicated that over the past 12 months, there have been no administrative or criminal findings of guilt for resident-on-resident sexual abuse that occurred at the facility. The Facility indicated that over the past 12 months, 18 grievances were files in total; none alleging sexual abuse or sexual harassment.

During the onsite portion of the audit, this auditor reviewed all resident grievances files over the past 12 months and inquired with randomly selected residents and staff whether they knew of any pertinent incident taking place. This auditor did not discover the existence of any relevant allegation. As a result, this auditor was not able to review any investigative reports and documentation of sanctions imposed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as residents are subject to disciplinary sanctions only pursuant to

a formal disciplinary process following an administrative finding or criminal finding of guilt for resident-on-resident sexual abuse.

115.278(b):
During the onsite portion of the audit, this auditor interviewed the Facility Director. The Facility Director reported that the sanctioning would depend on the nature of the abuse, the resident's disciplinary history, and comparable offenses. The Facility Director noted that resident-on-resident abuse had never been reported while this person has been employed at the Facility. The Director also reported that they would be referred for criminal prosecution and referred to a higher level of care.

As reviewed in provision (a) of this standard there were no investigative reports and documentation of sanctions imposed for this auditor to review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the facility attempts to impose sanctions that are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offense by other residents with similar histories.

115.278(c):
During the onsite portion of the audit, this auditor interviewed the Facility Director. The Facility Director reported that the disciplinary process considers 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. The Facility Director noted that she was not aware of resident-on-resident abuse ever being reported at this Facility.

As reviewed in provision (a) of this standard there were no investigative reports and documentation of sanctions imposed for this auditor to review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the facility reported that its disciplinary process considers 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.

115.278(d):
During the pre-onsite portion of this audit, the Facility indicated that it does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse as it does not employ medical and mental health staff. Because the facility does not employ medical and mental health staff and as a result does not offer the pertinent therapeutic intervention(s), this provision is not applicable.

115.278(e):
During the post-onsite audit portion of this audit, the Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency reported, "Centre Inc.'s document titled, 'Centre Residential Services Contract,' and North Dakota Department of Correction's Appendix A and the Bureau of Prison's Prohibited Acts clearly identify that [non-consensual acts] is [the] prohibited behavior and outlines in detail the applicable discipline" (p. 8). A review of these documents, establish that the prohibited behavior is nonconsensual sexual conduct with staff. A review of the resident handbook binder obtained while onsite reveals that these documents are located among the materials provided to the resident at intake.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.278(f):
During the pre-onsite portion of this audit, the Facility indicated in the PAQ that the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The facility provided this auditor with a form titled, "Centre Residential Services Contract" in support of its compliance. However, a search of this document does not establish that it contains any prohibition of disciplinary action being taken.

Prior into entering into a period of corrective action, the agency had not demonstrated that it prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.278(g):
During the pre-onsite portion of this audit, the Facility provided "Centre Residential Services Contract." Section C(I)(15) prohibits all sexual activity between residents; "Physical/Sexual Contact- Residents (regardless of gender) are to maintain appropriate physical boundaries with each other and with visitors. An appropriate distance between residents is generally at least one and one-half (1 & 1/2) feet (personal space). There will be no sexual activity, excessive affectionate mannerism, or inappropriate physical contact between residents and visitors or between residents. Judgment as to "excessive" resides with the on duty staff member. This includes any physical contact with another in Centre Inc. or on the grounds other than a brief embrace and/or kiss at the times of arrival and departure of an approved visitor. Also, includes engaging in any sexual act with an unauthorized person(s)" (p. 17). The agency defines sexual abuse/assault separately in subsection C(I)(2) and indicated in their PAQ responses that the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:
1. Develop and implement a disciplinary protocol that establishes a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact. As stated in the narrative portion to provision (e), the Agency demonstrated compliance without the need for corrective action.
2. Develop and implement disciplinary protocol that prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred.

Final Audit Report Reassessment:
During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (f) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. The Director of Operations will update P -14 “Program Rules and Discipline” policy and procedure to include language that prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred. This policy update and memorandum communicating the addition to all personnel will occur by 3-15-20.
The Auditor’s proposed methodology for reassessment was to review updated policy and procedures and confirm dissemination to disciplinary staff. The agreed upon timeline for completing this corrective action was March 15, 2020. Due to the efforts needed to combat the spread of COVID-19 (“Coronavirus”) and its impact on resources and staff attention during this time, the Agency was given until March 20, 2020 to demonstrate compliance in this standard.

On March 18, 2020, the PREA Coordinator/Director of Operations provided the auditor with a policy revision to P-14: Program Rules and Discipline. This revision added, “Centre Inc. prohibits disciplinary action for all repots of sexual abuse made in good faith when they are made based upon a reasonable belief that the alleged conduct occurred” (p. 1). This was disseminated to all program managers and supervisory personnel, demonstrated by a memorandum and email to those personnel. The auditor confirmed via telephone interview with the Director of Operations that the facility did not have a report of sexual abuse made during the period of corrective action.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.282 (c)

- Are resident victims of sexual abuse 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? ☒ Yes ☐ No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.282: Access to emergency medical and mental health services.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
2. Interviews
    a. PREA Coordinator
    b. Community-based medical provider
    c. Residents who Reported a Sexual Abuse
    d. Security Staff and Non-Security Staff First Responders
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):
115.282(a):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(D)(3)(h) of this policy establishes that "(r)esident victims of sexual abuse will receive timely and unimpeded access to emergency mental health care and ongoing medical and mental health care at no cost to the resident (during the offender's Residential program participation)" (p. 9). Section I(D)(3) further establishes,

"(v)ictims of sexual assault will be referred to the appropriate/applicable community medical, psychological, and law enforcement agencies for treatment and gathering of evidence. The referral and follow up will include provisions that include but are not necessarily limited to: a. The extent of physical injuries is documented and with the victim's consent, the examination includes the collection of evidence from the victim;
b. Testing for sexually transmitted diseases (for example, HIV, gonorrhea, hepatitis, and other diseases); c. Counseling as appropriate; d. Prophylactic treatment and follow up for sexually transmitted diseases will be offered as appropriate; e. Female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. Following the physical examination, there is availability of an evaluation by a mental health professional to assess the need for crisis intervention counseling and long-term follow-up" (p. 8–9).

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that all resident victims of sexual abuse would receive immediate and unimpeded access to emergency medical treatment and crisis intervention. The PREA Coordinated reported that any treatment would be at no cost to the resident and in all contracts for service, there is a provision that Centre, Inc. can invoice the respective government agency for reimbursement of these costs. The PREA Coordinator further reported that in the event that the referring agency does not reimburse, Centre, Inc. would cover the cost of the services; at no point in time would a resident be required to pay for any medical treatment as a result of being a victim of sexual abuse. The PREA Coordinator reported that Centre, Inc. has an ongoing relationship with Sanford Health. An executive-level representative of Sanford Health reported to this auditor that Sanford and Centre, Inc. have an ongoing relationship where Sanford Health provides emergency medical care (and other related medical care) for residents at all of Centre, Inc.'s facilities. It was further established that once a resident arrives at a Sanford Health location, the nature and scope of any emergency medical treatment or crisis intervention is determined by practitioners at Sanford Health. Lastly, the representative reported that all patients receive discharge paperwork that includes the timeliness of services provided, the nature and scope of medical services provided, and any discharge recommendations. The PREA Coordinator indicated that the facilities would document the timeliness of the emergency medical treatment and crisis intervention services that were provided, the response by program staff that acted as first responders, and timely information and services concerning contraception and sexually transmitted infection prophylaxis. The PREA Coordinator indicated that the need for these records have never occurred as there has not been a reported instance of sexual abuse in this facility.

There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.282(b):
During the onsite portion of this audit, this auditor interviewed security and non-security staff first responders. The facility indicated that all Residential Specialists are the facility's first responders. As a

result, this auditor interviewed four Residential Specialists and asked them to the first responder protocol. All staff indicated in the event they were the first to respond or learn of a sexual assault, they would call for additional staff, call 9-1-1, notify the on-call, separate the alleged victim and accuser, secure the scene from contamination, and after a discussion with the alleged victim call the Mental Health Crisis line Southeast Human Services, if requested. The three non-security first responders interviewed (case managers) all reported that their responsibility in this type of situation would be to call for additional staff support, call 9-1-1, and notify the on-call of the situation.

As noted in subsection (a) of this standard, the facility has not had a report of sexual abuse occurring in the facility for this auditor to review. This auditor reviewed the scope of services offered by Southeast Human Services; their website indicates that this agency has during business hour and after-hours crisis hotlines. This auditor observed a flier containing these crisis number displayed in the control room on both units.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. Having no medical or mental health practitioners on-site, the facility has evidenced a consistent procedure among security and non-security first responders the necessity to immediately take steps to protect the victim and notify medical (9-1-1) and mental health practitioners (Southeast Human Services).

115.282(c):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(D)(3)(h) of this policy establishes that resident victims will have access to "(t)esting for sexually transmitted diseases (for example, HIV, gonorrhea, hepatitis, and other diseases); c. Counseling as appropriate; d. Prophylactic treatment and follow up for sexually transmitted diseases will be offered as appropriate; e. Female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services" (p. 8–9).

As noted in subsection (a) of this standard, this facility does not employ any medical or mental health practitioners as verified by this auditor's review of the staff roster on the first day of the onsite portion of this audit. A telephonic interview with an executive-level representative of Sanford Health revealed that Centre, Inc. has an ongoing relationship with Sanford Health for Sanford to provide Centre's residents unimpeded access to emergency care and treatment.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.282(d):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(D)(3)(h) of this policy establishes that "(r)esident victims of sexual abuse will receive timely and unimpeded access to emergency mental health care and ongoing medical and mental health care at no cost to the resident (during the offender's Residential program participation)" (p. 9).

As noted in subsection (a) of this standard, the facility has not had a report of sexual abuse occurring in the facility for this auditor to review. During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that under no circumstances would Centre, Inc. required a resident to pay for treatment services as a result of being a victim of sexual abuse. He further reported that Centre, Inc. would not condition payment of these services on whether the victim names the abuser and/or cooperates with the investigation arising out of the incident.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be*

sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.) ☒ Yes ☐ No ☐ NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.283: Ongoing medical and mental health care for sexual abuse victims and abusers.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 1/31/2019)
    d. PREA Rating Assessment Manual
    e. Initial Assessment/Re-assessment PREA (form)
2. Interviews
    a. Community-based medical providers

b. Residents who Reported a Sexual Abuse
c. Residents who Disclosed Sexual Victimization During Risk Screening
d. Security Staff and Non-Security Staff First Responders
e. Rape and Abuse Crisis Center representative
f. Case management staff

3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.283(a):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with a document titled, "PREA Rating Assessment Manual." Section 3(ii) of this manual establishes that if a client scored as a known or potential victim during his screening, initial PREA assessment, or reassessment, "[t]he Case Manager will refer the client to community mental health services for any necessary follow-up" (p. 1).

There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered. An additional four residents were interviewed that reported prior victimization during intake. One of the four residents reported that she told staff she did not want to talk about this topic when staff informed her of available services. The other three residents interviewed reported that staff offered them such services.

At the time of the onsite portion of this audit, the facility had not demonstrated a procedure that offers all residents a medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in prison, jail, lockup, or a juvenile facility.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.283(b):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with a document titled, "PREA Rating Assessment Manual." Section 3(ii) of this manual establishes that if a client scored as a known or potential victim during his screening, initial PREA assessment, or reassessment, "[t]he Case Manager will refer the client to community mental health services for any necessary follow-up" (p. 1).

As noted in subsection (a) of this standard, the facility has not had a report of sexual abuse occurring in the facility for this auditor to review. Two residents interviewed that reported prior victimization elected to have staff refer or schedule a medical or mental health evaluation and informed this auditor that within the week was intake at the referred to community-based program. A spot check review of one of these residents itineraries and accountability logs in SecurManage evidenced that she was allowed out of the program for treatment.

At the time of the onsite portion of this audit, the facility had not demonstrated that it has procedures in place to ensure the evaluation and treatment for such victims include "referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody."

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.283(c):
During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that all resident victims of sexual abuse would receive access to community-based medical and mental health treatment. The PREA Coordinated reported that Centre, Inc. has an ongoing relationship with Sanford Health. An executive-level representative of Sanford Health confirmed that Sanford and Centre, Inc. have an ongoing relationship where Sanford Health provides emergency medical care for residents at all of Centre, Inc.'s facilities. The PREA Coordinator reported the mission of Centre, Inc., in part, is to connect residents transitioning home through on of it facilities with community-based agencies in their own community in order for the greatest likelihood that that resident will continue their engagement post-release. This auditor also interviewed four case management staff at this facility. All four staff indicated that all residents, including those that have reported prior sexual abuse or victimization, are offered mental health services through one of two primary community-based providers.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. The facility does not offer internal medical or mental health services, instead it utilizes community-based organizations to provide their residents with these services.

115.283(d)-(e):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section II(D)(3)(e) of this policy establishes, "[f]emale victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services" (p. 9).

As noted in subsection (a) of this standard, the facility has not had a report of sexual abuse occurring in the facility for this auditor to review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as it has demonstrated that in the event a resident reports sexual abuse she will be offered pregnancy tests and receive timely comprehensive information about and timely access to lawful pregnancy-related medical services.

115.283(f):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(D)(3)(h) of this policy establishes that resident victims will have access to "(t)esting for sexually transmitted diseases (for

example, HIV, gonorrhea, hepatitis, and other diseases) . . . [and] [p]rophylactic treatment and follow up for sexually transmitted diseases will be offered as appropriate" (p. 8–9).

As noted in subsection (a) of this standard, the facility has not had a report of sexual abuse occurring in the facility for this auditor to review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.283(g):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(D)(3)(h) of this policy establishes that "(r)esident victims of sexual abuse will receive timely and unimpeded access to emergency mental health care and ongoing medical and mental health care at no cost to the resident (during the offender's Residential program participation)" (p. 9).

As noted in subsection (a) of this standard, the facility has not had a report of sexual abuse occurring in the facility for this auditor to review. During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that under no circumstances would Centre, Inc. required a resident to pay for treatment services as a result of being a victim of sexual abuse. He further reported that Centre, Inc. would not condition payment of these services on whether the victim names the abuser and/or cooperates with the investigation arising out of the incident.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.283(h):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with its "Initial Assessment/Re-Assessment Prison Rape Elimination Ace (PREA)" screening form. Page two of this form contain the following excerpt: "Re-Assessment Only: Known "Resident on Resident" Abuser; if "Yes" make referral to medical health professional for a mental health evaluation to occur within 60 days. Ensure access to mental health care practitioner's recommended treatment is made available and on-going follow up is included within the resident's Mutually Agreed Upon Plan (MAP)."

During the onsite portion of this audit, this auditor conducted 20 resident file audits. The "Initial Assessment/Re-Assessment PREA" screening form that was provided was evidenced to be utilized during the resident intake. The case file audit revealed no residents being identified as a known resident-on-resident abuser. In addition, this auditor interviewed 12 staff at the facility; three of which were case management staff. All case management staff indicated that they have not referred any resident-on-resident abusers for mental health evaluation and treatment as deemed appropriate. All case management staff indicated that they refer all known victims to the Rape and Abuse Crisis Center in Fargo North Dakota and that they do not, as a matter of course, make any referrals for potential or known predators. This auditor spoke with an executive-level representative of the Rape and Abuse Crisis Center. This person reported that over the prior 12-month period, Centre, Inc. referred 15 individuals (between the male and female facilities) to the Rape and Abuse Center. Additionally, this person

informed this auditor that the Rape and Abuse Crisis Center does offer a batterer's program once a week in the evenings when no victim services are scheduled but that program is a fee-for-service program. The representative could not confirm for this writer whether any resident of Centre Inc. had participated in that program.

At the time of the onsite portion of this audit, the facility did not have a mechanism in place to conduct a mental health evaluation of all known resident-on-resident abusers and offer treatment when deemed appropriate.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

1. Develop and implement a procedure to ensure all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility are offered medical and mental health evaluation and, as appropriate, treatment.
2. Develop and implement a procedure to ensure the evaluation and treatment for victims of sexual abuse include referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.
3. Develop and implement a procedure to ensure a mental health evaluation is conducted of all known resident-on-resident abusers and offer treatment when deemed appropriate.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a), (b), and (h) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to these provisions:

1. The Director of Operations will update P-19 "Sexual Abuse/Assault Prevention and Intervention" to include a procedure to ensure all known resident-on-resident abusers are referred for a mental health evaluation and that treatment is offered when the mental health practitioner deems it is appropriate. The Director of Operations will update the form titled, "Initial Assessment/Re-Assessment PREA Screening" form to account for this update.
2. All Case Managers and Program Directors will be re-trained on this update.

The Auditor's proposed methodology for reassessment was to review updated policy and procedures; review any referrals for services, if available; and confirm retraining. The agreed upon timeline for completing this corrective action was March 15, 2020.

On January 31, 2020, the PREA Coordinator/Director of Operations provided the auditor with a policy revision to P-19: Sexual Abuse/Assault Prevention and Intervention. This revision added, "Centre Inc. personnel adhere to PREA Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers. Case Managers and/or Program Directors are responsible for ensuring all known resident-on-resident abusers are referred for a mental health evaluation and that treatment is offered when the mental health practitioner deems it is appropriate. In applicable cases, the Case Manager or designee will complete the referral within 60 days of learning of such abuse history" (p. 14).

The auditor was provided a document establishing that the policy was reviewed with all case management staff on February 15, 2020. Further, a conversation with the Director of Operations revealed that this procedure is being reviewed on an on-going basis through staff supervision. Since the policy revision, there have been three individuals that were classified as having prior victimization during their intake assessment. The facility provided the auditor with case note summaries entered into SecurManage evidencing a referral and initial consultation with the Rape and Abuse Crisis Center. This referral was made during the orientation period (within the first three days of the resident's arrival).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.286: Sexual abuse incident reviews.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Reporting and Handling of Significant or Unusual Incidents SP-9 (*reviewed* 11/1/2018)
    d. Reporting and Handling of Significant or Unusual Incidents SP-9 (*updated* 1/29/2020)
    e. Documentation of criminal and administrative investigations
    f. Sexual abuse incident review documentation (SART Report)
2. Interviews
    a. PREA Coordinator
    b. Facility Director of Designee
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):
115.286(a):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(A) establishes that the Program Director "will serve as the PREA Compliance Officer. This staff person will be responsible . . . to review all reports. Process all incidents with the Director of Operations – PREA Coordinator" (p. 1). Section II(D)(3)(g) establishes "[a] 'Report of Significant Incident' is completed and forwarded to the Director of Operations, Executive Director" for review (p. 9). Section II(I)(A)(2) further establishes that "[a]t the completion of the investigation, the staff investigator will complete the "Report of Significant Incident" and attach/compile all the documentation, including the investigative report,

incident reports with disposition, medical and counseling evaluation findings, and recommendations for post release treatment, and place the original in the client's case file, and forward a copy to the Director of Operations or designee" (p. 14). The Facility also provided Staff Practices (SP-9): Reporting and Handling of Significant or Unusual Incidents. Section I establishes, "The Director of Operations will assign staff members to a Sexual Abuse Response Team (SART) for each incident involving potential sexual abuse and or harassment. Incidents involving possible employee standard of conduct violations (including volunteers and contractors) will have administrators and the employee's or department's manager assigned to the SART. Incidents involving residents without staff, volunteers and contractors will consist of assigned clinical staff, Residential Specialist II and managers/directors. The SART will complete a Sexual Abuse Response Team Report for each incident. The SART Report assesses for required aspects as outlined in PREA Standard 115.286" (p. 2). SP-9 further establishes, "[a]ll qualifying critical incidents will be investigated by the Director of Operations or designee and will include a debriefing after each such incident. The investigation and debriefing shall include but not be limited to: a review of staff and client actions during the incident; a review of the incident's impact on staff and clients; a review of corrective actions taken and still needed; and plans for improvement to avoid another incident. The debriefing process shall include coordination and feedback about the incident with designated staff of the facility/program as soon as possible after the incident" (p. 3). The facility reported that in the past 12 months, there was one criminal and/or administrative investigation of alleged sexual abuse completed at the male facility. The facility reported no instances being alleged at the facility but provided the reports in order this auditor to review established protocols.

During the onsite portion of this audit, this auditor reviewed documentation of completed criminal and administrative investigations into the above-referenced investigation. This documentation included the formation of a Sexual Abuse Response Team and documentation that this team reviewed the incident at the conclusion of the investigation. This was demonstrated by inclusion of a document titled, "Sexual Abuse Response Team (SART) Report."

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. The Facility has demonstrated that it conducts sexual abuse incident reviews at the conclusion of every criminal or administrative sexual abuse investigation.

115.286(b):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with a "Report of Significant or Unusual Incident." The instructions on this form inform staff that "[a]ll qualifying critical incidents will immediately be reported to and investigated by the Director of Operations or designee and will include a debriefing after each such incident." The "immediate report" referenced in this form is an immediate report of the allegation or incident itself. Responsive to this provision is the timeframe for a post-investigation review of the incident.

A review of the criminal investigation file referenced in provision (a) reveals that the State's Attorney's Office sent correspondence to the Facility of their intentions not to prosecute this allegation criminally. This was dated September 10, 2018. Additionally, notification of this result to the former resident was made on September 25, 2018 as evidenced by documentation within the investigation packet. However, the Sexual Abuse Response Team (SART) Report is undated and does not reference a date in which it occurred.

The Facility is unable to demonstrate that an incident review is conducted within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.286(c):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Staff Practices (SP-9): Reporting and Handling of Significant or Unusual Incidents. Section I establishes, "The Director of Operations will assign staff members to a Sexual Abuse Response Team (SART) for each incident involving potential sexual abuse and or harassment. Incidents involving possible employee standard of conduct violations (including volunteers and contractors) will have administrators and the employee's or department's manager assigned to the SART. Incidents involving residents without staff, volunteers and contractors will consist of assigned clinical staff, Residential Specialist II and managers/directors."

A review of the criminal investigation file referenced in provision (a) reveals that the SART was comprised of Facility level management, investigative staff, law enforcement personnel, and the PREA Coordinator. The PREA Coordinator reported that this SART was limited due to the nature of the allegation, but included the employee's supervisor.

During the onsite portion of the audit, this auditor interviewed the Facility Director. The Director reported that all incidents of sexual abuse are reviewed by the Program Manager, the PREA Compliance Officer (at the time of the audit this position was vacant), PREA Coordinator/Director of Operations, and Investigator. The Facility Director informed this auditor that the facility does not have any medical or mental health practitioners on staff.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.286(d):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Staff Practices (SP-9): Reporting and Handling of Significant or Unusual Incidents. Section I establishes, "[a]ll qualifying critical incidents will be investigated by the Director of Operations or designee and will include a debriefing after each such incident. The investigation and debriefing shall include but not be limited to: a review of staff and client actions during the incident; a review of the incident's impact on staff and clients; a review of corrective actions taken and still needed; and plans for improvement to avoid another incident. The debriefing process shall include coordination and feedback about the incident with designated staff of the facility/program as soon as possible after the incident" (p. 3).

A review of the criminal investigation file referenced in provision (a) reveals that the SART includes the following review topics in its Sexual Abuse Response Team (SART) Report: 1) whether there are any recommendations for improvement of policy or practice; 2) whether the allegation and or incident was motivated by lesbian, gay, bisexual, transgender or intersex identification; 3) an examination of the area in the facility where the incident occurred to expose any potential physical barriers that may enable the abuse; 4) whether staffing levels were adequate in that area during all shifts; and 5) whether monitoring equipment/technology is sufficient to protect residents from sexual abuse and sexual harassment. As referenced above, this report was documented and included any recommendations for improvement. The Executive Director and PREA Coordinator were evidenced to be a part of the SART.

During the onsite portion of the audit, this auditor interviewed the Facility Director, PREA Coordinator (who also organizes the Incident Review Team). The Facility Director reported that the SART examines paragraphs (d)(1)-(d)(5) of this section. Additionally, the Director reported that in the event of any type of serious incident, the SART reviews the following: the impact on staff/clients, corrective action needed, review if policy and procedure was followed correctly, is there a need to initiate or revise policy or procedure, and a plan for improvement to avoid future incidents. The PREA Coordinator reported that the SART always prepares a report indicating its findings, including any determinations made pursuant to this standard. The PREA Coordinator also reported that he is always a member of the SART; additionally, once the review has been completed, he is responsible for ensuring that the facility follows through and implements any corrective action developed. During the interview with the PREA Coordinator, the PREA Coordinator reviewed and discussed a completed Report form that evidenced determinations made pursuant to paragraphs (d)(1)-(d)(5) of this provision.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.286(e):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with a completed SART Report from 2016 evidencing a recommendation that the involved staff needed to be retrained in how to conduct a pat-down search. The Report included the date and time in which the staff person completed that training.

A review of the criminal investigation file referenced in provision (a) reveals that the SART Report identified that the alleged conduct occurred outside of the program, that the staff person was no longer employed at the facility, and that this behavior was isolated. The SART did not make any recommendations for improvements pursuant to paragraphs (d)(1)-(d)(5) as a result of that incident.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

1. Develop protocol that allows the facility to demonstrate that it conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.

Final Audit Report Reassessment:
During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (b) of this standard. The Agency provided the auditor with a “response and corrective action plan” on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:
1. The Director of Operations will update SP-9 “Reporting and Handling of Significant or Unusual Incidents (including Critical Incidents)” policy and procedure to require the SART team to conduct and complete a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The protocol update and memorandum to all personnel communicating this update will occur by 3-15-20.
The Auditor’s proposed methodology for reassessment was to review policy and procedure updates and review SART team reports, if available. The agreed upon timeline for completing this corrective action was March 15, 2020.

On January 29, 2020, the PREA Coordinator/Director of Operations emailed this auditor a revised policy SP-9: Reporting and Handling of Significant or Unusual Incidents (including Critical Incidents), effective 1/29/2020. The following additions were added to this policy: "The SART team is also required to conduct and complete a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation . . . PREA - Sexual Abuse Response Team (SART) will conduct and complete a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation" (p. 3-4). On March 13, 2020, the auditor conducted a telephone interview with the PREA Coordinator/Director of Operations. The Director of Operations reported that there are no new SART team reports to review as there have not been any critical incidents reported.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.287: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.287: Data collection.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
   a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
   b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
   c. Reporting and Handling of Significant or Unusual Incidents SP-9 (*reviewed* 11/1/2018)
   d. PREA Annual Report and Corresponding Agency Review (Cover Letter)
   e. Investigative Files
2. Interviews
   a. PREA Coordinator
   b. Facility Director of Designee
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings (By Provision):
115.287(a):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section I(C) establishes definitions for the following concepts: Non-consensual sexual act, abusive sexual contact, staff sexual misconduct, staff sexual harassment, sexual assault (rape), client sexual contact, client sexual harassment (p.4). P-19 additionally includes PREA definitions establishes in 28 C.F.R. 115.5 and 28 C.F.R. 115.6 (p. 4-6).

The facility also provided this auditor with Reporting and Handling of Significant or Unusual Incidents SP-9. SP-9 establishes the collection of uniform data when completing the Report of Significant or Unusual Incident Form. Section II(A)(1) establishes,

"[t]he staff person or person's involved or first becoming aware of a reportable incident must fully and comprehensively complete the Report of Significant Incident Report Form. The Report of Significant Incident must include but is not limited to:

a. Facility/Program and Location of Incident;
b. Incident Category;
c. Date and time staff became aware of the incident being reported;
d. Description of the incident in chronological order including: who (all person's involved & or witnesses) , what (clearly describe the incident being reported include all details, include facts), when (includes dates and times of events as applicable), where (include incident destination, full address, and specific location within a building or area if applicable), and how (if the factual basis of how something happened is known, it should be included);
e. Indicate whether or not there was use of force and/or an exposure control incident, including whether or not universal precautions were followed;
f. A description of any follow-up action taken and an indication of what must be completed from that point forward;
g. List who was notified including Centre chain of command (Include date and time and form of notification), any outside authorities (law enforcement, ambulance, hospital, fire department, other), and specific referral agent contact person (include the date and time of each notification);
h. Indicate whether or not the media has inquired about the situation; and
i. Signature, title of person and date and time of completion of report" (p. 3).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.287(b):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section II(I)(3) establishes, "[o]n or around January 1 of each year, the Director of Operations or designee will review the Significant Incident Reports, and tally statistics on the number of Non-consensual Sexual Acts, Abusive Sexual Contacts, Consensual Sexual Contacts, Staff Sexual Misconduct, and Sexual Harassment incidents. The Director of Operations will share/forward this information to its referral agencies and licensing authority oversight personnel as requested" (p. 14). The Facility also provided this auditor with a document titled, "PREA Assessment/Centre Inc.'s Residential Reentry Program located at 3501 Westrac Drive, Fargo, ND 58103." This report includes an aggregated report listing all substantiated, unsubstantiated, and unfounded sexual abuse allegations reported in the past 12 months. Attached to this report was the Facility's PREA Annual Report that had been completed. The document was dated, February 26, 2018.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.287(c):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with the Facility's PREA Annual Report. The annual report included aggregate information on the following types of incidents: 1) client-on-client non-consensual act (coercion), 2) client-on-client sexual assault, 3) client-on-client abusive sexual contact, 4) client-on-client consensual sexual contact, 5) client-on-client sexual harassment, 6) staff-on-client sexual harassment, 7) staff sexual misconduct, & 8) staff-on-client sexual assault.

During the onsite portion of the audit, the Facility provided this auditor with a monthly and annual utilization reports that tracked the daily population and total number of residents admitted and discharged.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the facility collects aggregated data necessary to answer the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

115.287(d):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section II(I)(A)(2)-(3) establishes, "[a]t the completion of the investigation, the staff investigator will complete the "Report of Significant Incident" and attach/compile all the documentation, including the investigative report, incident reports with disposition, medical and counseling evaluation findings, and recommendations for post release treatment, and place the original in the client's case file, and forward a copy to the Director of Operations or designee. On or around January 1 of each year, the Director of Operations or designee will review the Significant Incident Reports, and tally statistics on the number of Non-consensual Sexual Acts, Abusive Sexual Contacts, Consensual Sexual Contacts, Staff Sexual Misconduct, and Sexual Harassment incidents. The Director of Operations will share/forward this information to its referral agencies and licensing authority oversight personnel as requested" (p. 14).

A review of the criminal investigation packet referenced in provision 286(a) reveals that the facility maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The investigation file includes each of those items. Additionally, data from the investigation file was reported by the program in its 2018 PREA Annual Report.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant.

115.287(e):
During the pre-onsite portion of this audit, the Facility indicted that this standard was not applicable as the agency does not contract with other entities for the confinement of its residents.

During the onsite portion of the audit, this auditor interviewed the Executive Director of Centre, Inc. The Executive Director reported that Centre Inc. does not contract with other private or public entities for the confinement of its residents.

Based upon the review and analysis of all the available evidence, the auditor has determined that this provision is not applicable.

115.287(f):
During the pre-onsite portion of this audit, the Facility indicted that this standard was not applicable as the agency reported the Dept. of Justice has not requested agency data.

Based upon the review and analysis of all the available evidence, the auditor has determined that this provision is not applicable.

Standard 115.288: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.288: Data review for corrective action.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. PREA Annual Report and Corresponding Agency Review (Cover Letter)
    c. PREA Annual Report and Corresponding Agency Review (*dated* 1/3/2020)
    d. Agency website
2. Interviews
    a. PREA Coordinator
    b. Agency Head
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.288(a):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with the Facility's PREA Annual Report. The annual report included aggregate information on the following types of incidents: 1) client-on-client non-consensual act (coercion), 2) client-on-client sexual assault, 3) client-on-client abusive sexual contact, 4) client-on-client consensual sexual contact, 5) client-on-client sexual harassment, 6) staff-on-client sexual harassment, 7) staff sexual misconduct, & 8) staff-on-client sexual assault. That information is reported a document, titled: "PREA Assessment/Centre Inc.'s Residential Program." The pertinent portion of this assessment features the following excerpt: "[i]n the past twelve-month period one (1) PREA allegation was reported and investigated. A SART team was assigned to this allegation. This assessment found that staff maintained fidelity to Policy and Procedure while investigating this incident."

During the onsite portion of this audit, the auditor interviewed the Agency Head and PREA Coordinator. The Executive Director of Centre Inc. reported that Centre's PREA Coordinator keeps statistics. Centre reviews, analyzes and discusses trends annually. Centre also evaluate each reported allegation to determine if policy and practice is sufficient or could be improved. Centre considers training needs as well during that assessment. The PREA Coordinator reported that on an annual basis the Director of Operations completes and reviews the agency's Significant Incident Report for category codes that correspond to incidents that would qualify as Sexual Abuse/Harassment. This data is then utilized to create the PREA Annual Report. If certain incident(s) become more prevalent then they would be targeted and analyzed to ensure proper corrective measures are in-tact and or need strengthening including protocol assessment. All Centre data is securely retained on password secured computer data bases. The PREA Coordinator also reported that the Director of Operations completes Annual Reports and an Annual Assessment for each location statewide. The assessment accompanies the report and it assess any corrective actions taken to ensure on-going effectiveness. The PREA Coordinator informed this auditor that in the event the agency established any problem areas or corrective action, these items would be assessed on an ongoing basis and included in the subsequent year's annual report.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant.

115.288(b):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and indicated that there were "[n]o corrective actions indicated in prior years." This auditor was able to corroborate this report by reviewing prior years' annual reports. However, although the agency has reported and sufficiently demonstrated that they evaluate key data pursuant to paragraph (a) of this standard, this provision requires that comparison be included in the current year's data and corrective actions with those prior years in addition to an assessment of the agency's progress in addressing sexual abuse. The comparison and the assessment must be included in the report.

A review of the Annual Report establishes that it contains the following excerpt: "[i]n the past twelve-month period one (1) PREA allegation was reported and investigated. A SART team was assigned to this allegation. This assessment found that staff maintained fidelity to Policy and Procedure while investigating this incident." A plain reading of this excerpt is that the agency conducted an assessment of that particular incident.

The annual report lacks a comparison of the current year's data with those from prior years and an assessment of the agency's progress in addressing sexual abuse.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.288(c):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided a link to the Agency's website: http://centreinc.org/PREA/. A review of this website reveals that it contains a link to Centre Inc.'s Annual PREA Reports and Assessments, as well as PREA audit reports and pertinent policies and procedures, MOUs, and informational notices.

During the onsite portion of the audit, this auditor interviewed the Agency Head. The Executive Director of Centre Inc. reported that he approves annual reports pursuant to this provision.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.288(d):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and reported that, "nothing [is] redacted." Comparing the 2018 Annual Report provided as part of this PREA audit to the 2018 Annual Reports available on the Agency's website evidences the same report.

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that only personal identifying information (PII) is not included and/or redacted from the annual report. The PREA Coordinator reported that nothing is redacted from the approved annual report prior to its publication on the Agency's website.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

1. Ensure the annual report includes a comparison of the current year's data with those from prior years and an assessment of the agency's progress in addressing sexual abuse as required by paragraph (b) of this standard.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (b) of this standard. The Agency provided the auditor with a "response and corrective action plan" on October 21, 2019. The Agency and auditor developed the following corrective action plan with respect to this provision:

1. The Director of Operations will update future annual reports to include a comparison of the current year's data with those from prior years and include an assessment of the agency's progress in addressing sexual abuse.

The Auditor's proposed methodology for reassessment was to review the Facility's 2019 Annual PREA Report. The agreed upon timeline for completing this corrective action was March 15, 2020.

On January 6, 2020, the PREA Coordinator/Director of Operations provided this auditor with the 2019 PREA Assessment, dated January 3, 2020. The assessment includes a review of current year's data with prior years to ensure data "will continue to be assessed and compared to past data to ensure trends are being identified and progress is being made with addressing and combating sexual abuse" (p. 2).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

Standard 115.289: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.289: Data storage, publication, and destruction.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Pre-Audit Questionnaire (PAQ) responses
    b. Sexual Abuse/Assault Prevention & Intervention Policy P-19 (*effective* 5/4/2019)
    c. Information Practices, Records, Retention and Data: Statistics, Outcome Measures and Agency Cooperation SP-6 (*reviewed* 11/1/2018)
    d. PREA Annual Report and Corresponding Agency Review (Cover Letter)
    e. Agency website
    f. Historical data since August 20, 2012
2. Interviews
    a. PREA Coordinator
3. Site Review Observations:
    a. Observations during on-site review of physical plant

Findings (By Provision):

115.289(a):

During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Policy P-19: Sexual Abuse/Assault Prevention & Intervention. Section II(I)(A) establishes, "[a]ll case records associated with claims of sexual abuse, including incident reports, investigative reports, client information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and or counseling will be retained in accordance with Centre's record retention policy" (p. 14). The facility also provided this auditor with Staff Practices 6: Information Practices, Records, Retention and Data: Statistics, Outcome Measures and Agency Cooperation. Section I(A) establishes "Centre generated data is safeguarded from unauthorized and

improper disclosure and the computerized portion of our information system ensures confidentiality. Unauthorized disclosure may result in disciplinary sanctions up to and including termination. Unauthorized disclosure may also result in criminal or civil penalties. Administrative, Managerial and case management staff are responsible for updating, storing and retrieving client statistics" (p. 2).

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that all Centre data is securely retained on password secured computer data bases. While onsite, this auditor observed inactive staff computers. Each computer observed required a username and password to navigate. Additionally, during the entire course of this audit (pre/onsite/post), sensitive documentation was sent to this auditor using the Online Audit System or through encrypted emails.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.289(b):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and reported that agency policy requires that aggregated sexual abuse data from facilities under its direct control . . . be made readily available to the public at least annually through its website. The facility reported its website to be http://centreinc.org/PREA/.

A review of this website reveals that it contains a link to Centre Inc.'s Annual PREA Reports and Assessments, as well as PREA audit reports that contain aggregated sexual abuse data and pertinent policies and procedures, MOUs, and informational notices.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.289(c):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and indicated that before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. A review of the agency's website (www.centre.org) and the annual reports publicly available, this auditor was able to confirm that personal identifiers have been removed.

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that only personal identifying information (PII) is not included and/or redacted from the annual report.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.289(d):
During the pre-onsite portion of this audit, the Facility indicted compliance with this provision and provided this auditor with Staff Practices 6: Information Practices, Records, Retention and Data: Statistics, Outcome Measures and Agency Cooperation. Section I(C) establishes, "[t] he agency maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise" (p. 6).

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. This auditor requested to see sexual abuse data collected pursuant to § 115.287 since August 20, 2012. The PREA Coordinator displayed annual reports dating back to that time on his password-protected computer.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.401: Frequency and scope of audits.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Website: http://centreinc.org/PREA/
    b. Prior PREA Audit Reports
2. Pre/Onsite/Post-Audit Observations
    a. General observations during the audit process

Findings (By Provision):
115.401(a):
A review of the agency's website and prior Final Audit Reports revealed that the agency has four community confinement facilities (one in Mandan North Dakota, one in Grand Forks North Dakota, and two in Fargo North Dakota). Additionally, the agency also has two day programs, one in Grand Forks North Dakota and another in Mandan North Dakota.

Previously this facility was audited in conjunction with the 123 15th Street Facility (male unit) on September 7, 2016, which began the three-year audit period. The onsite portion of this current audit began on July 22, 2019. The Mandan Residential Re-entry Centre Final Audit Report completed on August 28, 2017. The Grand Forks Residential Transition Program Final Audit Report was completed on August 1, 2018.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision. During the prior three-year audit period, the agency ensured that each facility it operates was audited at least once.

115.401(b):
A review of the agency's website and prior Final Audit Reports revealed that the agency has four community confinement facilities (one in Mandan North Dakota, one in Grand Forks North Dakota, and two in Fargo North Dakota). One-third of its programs would equate to one program per year over the

course of the three-year audit cycle. As delineated above (*see* discussion of 115.401(a), the agency ensured that one program was audited each year during the prior three-year period.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.401(h):
During the onsite portion of this audit, this auditor had access to, and the ability to observe, all areas of the audited facility. The facility provided this auditor with unfettered access to the facility and its staff and residents.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.401(i):
During the pre-audit, onsite, and post-onsite portion of this audit this auditor was permitted to request and received copies of any relevant documents that this auditor requested, including but not limited to: facility logs, resident files, personnel files, policy and procedure manuals, postings, resident handbooks, intake and classification documents, etc.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.401(m):
During the onsite portion of this audit this auditor was permitted to conduct private interviews with residents and staff at various locations throughout the facility. The rooms chosen were confirmed to not have video or voice recording capabilities.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.401(n):
During the pre-audit potion of this audit residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

While onsite this auditor asked all residents interviewed whether they were made aware of and saw this auditor's notices that were displayed throughout the facility. All residents interviewed informed this auditor that the postings have been displayed for months. Additionally, the residents informed me that staff at the facility provide envelopes and stamps free of charge and that outgoing mail is not screened. This auditor also interviewed a direct care staff that was responsible for resident mail. This staff person reported that the residents can have access to envelopes and stamps free of charge and that any outgoing mail is left in an outgoing mail box for a United States Postal Services carrier to collect the next business day. This staff person informed this auditor that outgoing mail is not screen and any letters to this auditor would have been treated the same way.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.403: Audit contents and findings.
The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)
    a. Centre, Inc. Website: http://centreinc.org/PREA/
    b. Prior PREA Audit Reports
2. Interviews
    a. PREA Coordinator

Findings (By Provision):
115.403(f):

A review of the Agency's website reveals that all three Final Audit Reports were posted to its website within 90 days of its issuance by the auditor. Centre, Inc. has an agency website (www.centreinc.org) and has a page dedicated to the posting or PREA-related information (www.centreinc.org/prea/).

The Fargo Male and Female Units Final Audit Report completed September 7, 2016 is located at the following address: http://centreinc.org/wp-content/uploads/2015/05/Centre-Inc.-Final-PREA-2016.pdf.

The Mandan Residential Re-entry Centre Final Audit Report completed on August 28, 2017 is located at the following address: http://centreinc.org/wp-content/uploads/2017/09/Centre-Inc.-Mandan-2017-PREA-Report.pdf.

The Grand Forks Residential Transition Program Final Audit Report completed on August 1, 2018 is located at the following address: http://centreinc.org/wp-content/uploads/2018/11/Centre-Inc.-Grand-Forks-Transition-Final-PREA-Audit-Report-2018.pdf.

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator informed this auditor that all Final Audit Reports are immediately posted on Centre's website.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision. The agency has a dedicated PREA page on its agency website that makes available not only Final Audit Report to the general public but also memorandums of understanding with various local police departments, policy and procedures, relevant PREA notices, and its Annual Report.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[2] Auditors are not permitted to submit audit reports that have been scanned.[3] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Andy LeClair, Esq. March 20, 2020

Auditor Signature **Date**

[2] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[3] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.