PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: November 23, 2016

Auditor Information			
Auditor name: Ida M.Lewis			
Address: 8255 Sea Star Drive, Blacklick, Ohio 43004			
Email: idamlewis@gmail.com			
Telephone number: 614-439-5545			
Date of facility visit: June 27-29, 2016			
Facility Information			
Facility name: Renaissance Home for Youth			
Facility physical address: 6177 Bayou Rapides Road, Alexandria, LA 71303			
Facility mailing address: *(if different from above)* P.O. Box 7997, Alexandria, LA 71306			
Facility telephone number: 318-473-0530			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Angela Chustz			
Number of staff assigned to the facility in the last 12 months: 14			
Designed facility capacity: 24			
Current population of facility: 18			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 11 - 17			
Name of PREA Compliance Manager: Angela Chustz		**Title:** Executive Director	
Email address: angela@renaissancehome.org		**Telephone number:** 318-473-0530 ext. 14	
Agency Information			
Name of agency: Community Receiving Home, Inc. d/b/a Renaissance			
Governing authority or parent agency: *(if applicable)* N/A			
Physical address: 6177 Bayou Rapides Road, Alexandria, LA 71303			
Mailing address: *(if different from above)* P.O. Box 7997, Alexandria, LA 71306			
Telephone number: 318-473-0530			
Agency Chief Executive Officer			
Name: Angela Chustz		**Title:** Executive Director	
Email address: angela@renaissancehome.org		**Telephone number:** 318-473-0530 ext. 14	
Agency-Wide PREA Coordinator			
Name: Roosevelt Johnson		**Title:** Training Coordinator/PC	
Email address: roosevelt@renaissancehome.org		**Telephone number:** Click here to enter text.	

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) on-site audit of the Renaissance Home for Youth, group home (RHFY), in Alexandria, Louisiana was conducted on June 27-29, 2016, by Ida M. Lewis, from Blacklick, Ohio, a U.S. Department of Justice Certified PREA Auditor for juvenile facilities. Renaissance Home for Youth (RHFY) provides residential services and programs for both male and female residents. RHFY has 41 staff and the bed capacity of 24 (12 females and 12 males); however, on the day of the audit the resident population was 18 (nine males and nine females).

Pre-audit preparation included a thorough review of all documentation and materials submitted by RHFY along with the data included in the completed Pre-Audit Questionnaire. The documentation reviewed included agency policies, procedures, forms, education materials, training curricula, organizational charts, posters, brochures, client handbook and other PREA related materials were provided to demonstrate compliance with the PREA standards. This review prompted a series of questions and/or a need to see additional documentation. An Issue Log was developed that delineated the questions and additional documentation request. The Issue Log was submitted to the PREA Coordinator and PREA Compliance Manager (Executive Director) for review via email. The auditor participated a conference call with RHFY management team to discuss the items on the Issue Log. Answers to the questions were submitted by the RHFY management and reviewed by the auditor prior to the on-site audit.

On Monday, June 27, 2016, at 8:30am the auditor held the initial meeting with the RHFY's management team as follows: Angela Chustz, Executive Director/PREA Compliance Manager, Roosevelt Johnson, Training Coordinator/PREA Coordinator, Heidi Bordelon, Residential Services Manager, Kay Lowery, Fiscal Director, Shelley Ryan, Human Resources Director, Jon Baker, Safety Coordinator, Yvette Robertson, Girls Program Supervisor, Derrick Johnson, Boys Program Supervisor, Bernadette Fletcher, Administrative Services Manager, and Aubrey Straughter, ACA Contract Consultant. The meeting was followed by a tour of the RHFY Group Home escorted by the PREA Coordinator and the Executive Director (PREA Compliance Manager).

During the three-day on-site audit, the auditor was provided a private and secure space in the facility from which to work and conduct confidential interviews. Formal personal interviews were conducted with facility staff, residents, volunteers and contractors. The Auditor worked on-site over all three shifts conducting interviews, verifying documentations and conducting file reviews.

The auditor interviewed ten residents, five females and five males. RHFY has two housing units, one for females and one for males. Three of the ten residents identified as LBGQI and three were victims of sexual abuse in the community; one of the three was raped by a family member during a weekend pass home.

Twenty-three (56%) facility staff members were interviewed representing all three shifts (1st shift 7am-3pm; 2nd shift 3pm to 11pm; 3rd shift 11pm to 7am). Included in the twenty-three interviews were specialized staff including medical (contract staff), counseling, first responders, investigators (administrative), intake and screening, human resources and training individuals. The agency's Executive Director, who is also the PCM, and the PREA Coordinator were interviewed as well. The Auditor also communicated with the Chief of the Alexandria Police Department, the Deputy Coroner of Alexandria, who oversees the SANF/SANE nurses at the local hospital, and the Clinical Director of the local hospital emergency room, and the victim advocacy hotline.

Residents were interviewed using the recommended DOJ protocols that is designed to assess their knowledge of a variety of PREA protections and to generally and specifically assess their knowledge of reporting mechanisms available to residents to report sexual abuse or sexual harassment or retaliation. Staff was interviewed using the DOJ protocols to assess their retention of the PREA training to include, but is not limited to an overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges abuse, and first responder duties.

The auditor reviewed the personnel files of ten staff to determine compliance with the hiring and screening procedures, training mandates and background check practices. Case files of ten residents in the facility were reviewed to evaluate the sexual victimization screening, to assess the intake procedures and practices, and to verify the resident's PREA education activities. The training files of twelve staff were reviewed to verify that training was completed as required by policy and PREA standards.

There were three allegations of sexual abuse or sexual harassment in the past 12 months. The auditor reviewed the completed investigation report, which included the administrative investigation conducted by RHFY Investigator and the criminal investigation conducted by the Alexandria Police Department. All three allegations were determined as unsubstantiated.

During the on-site audit process, Yvette White, the Contract Monitor for OJJ came out to extend hospitability to the auditor. The auditor was treated with great hospitality during the visit and residents and staff were made readily available to the auditor at all times.

A closeout meeting was held on Wednesday, June 29, 2016, at 4:30pm with RHFY administration team.

DESCRIPTION OF FACILITY CHARACTERISTICS

Renaissance Home for Youth (RHFY) is a 24 bed community based receiving home for children in support of juvenile justice. It is operated by the Board of Directors and Advisors of the Community Receiving Home, Inc., a nonprofit corporation. The leadership of the Renaissance board is comprised of concerned citizens, judges and law enforcement officials who donate their time. Renaissance is licensed by the Louisiana Department of Children and Family Services and accredited by the American Correctional Association.

RHFY Mission: We believe in the value of children to the family and the community. We accept young people from every walk of life. We assess needs and provide programs for the body, mind and spirit of young people in need of protection and correction. We prepare them for the future, treat them with dignity and teach them responsibility.

The Renaissance Home for Youth (RHFY) campus is comprised of an administration unit, medical, detention center and a food service unit all enclosed in a one level building; a newly added school building sits near the edge of the property and two one level housing units (group homes) set on opposite sides of the administration unit. Each group home is inclusive of a social worker's office, counseling areas, staff office, kitchen/dining areas, laundry room, living room and a game room.

The housing unit for female residents is 3,800 square feet and is comprised of four (4) bedrooms and each bedroom sleeps up to three (3) females. There is one large bathroom for the females to share with triple stalls, privacy showers and sinks. Only one resident can occupy the bathroom at a time. There are two separate restrooms located in the staff area for staff. There are cameras monitoring throughout the group home, except for inside of the bathroom and bedrooms. PREA information, contact information, the PREA Audit Notice are posted in the group home. There is a sign at each entrance into the female group home reminding anyone of the opposite gender to announce their presence.

The male group home is 5,450 square feet. The housing unit for male youth has seven (7) bedrooms that are in elevated area of the house. Five (5) bedrooms have two (2) youth per room and two (2) bedrooms are single rooms. The bedroom area also has a leisure/gaming area, laundry area, night staff work area, linen storage, a large shower/bathroom on one end and an additional bathroom on the opposite end. The boys' group home also has a kitchen, dining room, living room/activity area, the social worker's office, the residential manager's office, Intake office, three additional bathrooms for Intake and staff and a storage area. Staff monitor showers and youth movement in the sleeping area is monitored by staff. There are cameras monitoring throughout the group home, except for inside of the bathroom and bedrooms. PREA information, contact information, the PREA Audit Notice are posted in the group home. There is a sign at each entrance into the male group home reminding anyone of the opposite gender to announce their presence.

The school has camera surveillance as well as motion lights throughout the building. Each class room has a door with a window and additional windows and an exit door on the other opposite side of the room. Residents are escorted to the restroom by a staff of the same gender.

RHFY group home residents are not allowed inside of Food Service. Meals are picked up and delivered to each group home. The nursing station is a one room area where the nurse mostly works and remains medical files and medication. She visits the residents on the housing units. Visitation and special visits also occur on the housing units. RHFY group home are staff secured at all times when residents are present.

SUMMARY OF AUDIT FINDINGS

This is the final PREA Audit Report. It is clear that the leadership of the RHFY have made PREA compliance a high priority and have expended great effort to ensure the sexual safety of residents in their care. It is further evident that staff and residents are invested in PREA as demonstrated through their knowledge and understanding of the protections and requirements.
With soft funding at hand in this current economy, the Executive Director has been exceptional in recruiting highly qualified licensed professional to supplement her sustainability plan RHFY. The level of collaboration with various community and extended resources to bring advocacy services to the residents is very impressive.
Upon a youth's arrival to RHFY, a direct care staff reviews the facility's rules, the grievance policy and youth handbook which includes the resident's rights to be free from sexual abuse, sexual harassment and retaliation.
Within 10 days of the resident's admission, the program supervisor or designee covers the PREA Handbook with the resident. The PREA Handbook clearly outlines the agency policy to protect the resident from sexual abuse, sexual harassment and retaliation; it also provides the name, phone number and address of agencies the youth can contact, as well as report to any staff. The Auditor reviewed the residents' education curriculum. The staff have a delivery plan to follow if a resident present special characteristic such Spanish speaking, visual impaired, hearing impaired, or has literacy issue.
During the first 72 hours of stay at the group home, the resident sleeps in specially located bed or bedroom. Within 72 hours, the resident meets with his/her social worker. The social worker administers the sexual victimization screening and other mental health assessments to determine classification and housing assignment. The social work also ensures that the resident has completed the 10-day training and addresses any other PREA concerns or requirements. The social worker also integrates PREA into the psycho-social groups.
All staff that are functioning in a specialize staff position have been trained utilizing NIC online courses. All staff receive general PREA Training which incorporates provisions of the PREA Standards. Direct care staff, along with other staff receive First Responders Training.
Cross-gender searches are prohibited and there has not been any transgender or intersex residents admitted in the previous 12 months.
RHFY also operates with a Coordinated Response Plan.

Based on an analysis of the supported evidence presented during the corrective action phase, it is determined that RHFY currently meets the following PREA Standards' provisions:

1. PREA Standard 115.313[e]
2. PREA Standard 115.386(d)
3. PREA Standard 114.371 (c, e, h, I, j, k)

The following standards are non-applicable:
1.Standard 115.312
2.Standard 115.366

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

After an analysis of the agency's policy – Prision Rape Elimination Act, an interviews with the PREA Coordinator and the PREA Compliance Manager, it is determined that the policy clearly outline agency's approach to create a zero tolerance and sexual safe environment against sexual abuse, sxual harrassment and retaliation. The agecncy has a policy that outlines the PREA Standards on how it will implements the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. However, there are opportunities for improvement in providing procedural guidelines. That is, the policy needs improvement in providing the step by step expected practices.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Renaissance Home for Youth – Group Home does not have contracts with other entitied for the confinement of residents. This standard is NON-APPLICABLE.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or

residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The Renaissance Home for Youth (RHFY) is a group home licensed by the state of Louisianan Child Protection Licensing Division. The state licensing requirements for staff to resident ratio is more restrictive than what is required in the PREA Standards.
The staffing plan is very detailed: Staffing pattern exceeds PREA Requirements: (Licensing requires 1:6 ratios daytime/1:12 night) Supervision during waking hours is1:6 ratio and supervision at night is 1:12 ratio. Staff on shift are responsible for the supervision/monitoring of the youth to ensure their safety and well-being. Staff supervise the residents' daily programs and activities and supervision on outings is a minimum of 1:6. Residents are not to be left unsupervised.
Only (1) resident is permitted in the back area of the girls' home or upstairs area of the boys' home at a time. This means that no more than one resident can go to their bedroom or bathroom area at a time. When showering, two residents utilize the showers at a time with staff of the same gender monitoring the showers. Each shower head is surrounded by a stall which allows for privacy. Staff must be in close proximity to the bathroom area when clients are showering in the girls' home. Boys' home staff shall remain upstairs at the staff desk area to supervise showers.
Annual Reviews of the staffing plan are conducted and documented and copy of the reviews were provided and there has not been deviation from the current staffing plan in the previous 12 months.
There have not been any major changes to the current buildings; however, a new a school building was added to the property in 2010. The management team decided on the floor plan and presented the floor plan to the Architect; all ideas came into play in the 2009 plan. The building is state of the art, equipped with surveillance cameras and motion lights inside and outside of the building.
PREA Unannounced Rounds are conducted on all shifts and documented on the unit logs. The auditor selected the dates of unannounced rounds and the facility provided videos of staff conducting PREA Unannounced Rounds. Unannounced rounds need more directions outlined in policy. PREA Unannounced Rounds are more than a routine security-round. The policy or training should give staff steps in conducting a PREA unannounced round. The rounds conducted by staff appear to have 2 different functions.

During the corrective period, PREA Unannounced Rounds are conducted on all shifts and documented in an Uannounced Rounds Report. The auditor reviewed footages of unannounced rounds during the corrective action phase as well as supporting documentation. The policy has been revised to provide detailed procedures for staff conducting the rounds. These procedures ensure that all staff conducting rounds do not loose sight of the purpose of unannounced rounds. The staff are being more thorough as they inspect the facility and they are engaging with the residents to check of the climate of the specific areas as outlined in policy. The auditor receved training documents to support that staff have been training on how to conduct unannounced rounds and the training emphasizes that the unannounced rounds are more than a routine security-check. This practice currentlys meets this provision of standards 115.313[e].

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
Cross-gender searches are prohibited. Searches are conducted by same gender staff, strip searches are conducted by the same gender staff and body cavity searches are prohibited by staff and can only be conducted by a medical professional.
In exigent circumstances, such as a hurricane, there are specified management level staff trained to conduct cross-gender searches. The facility's policy outlines how these type of searches are to occur. The training curriculum was reviewed as well. All searches are documented.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY has taken the appropriate steps to acquire services for residents with special needs. Each resident is assigned a mentor (direct care staff) who reviews, and read if necessary, the PREA material to the youth. Within 72 hours each resident is seen by the assigned social worker for additional services or resources. There is a MOU in place with the Alexandria Policy Department to offer interpretive services. There is an MOU with the Sisters of Holy Family – Sister Gloria Lewis, SSF, will provide Spanish-English Translation Services. The RHFY has not admitted any residents in need of an interpreter during the previous 12months. The audit notices were in English and Spanish.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff interviews according to the designated interview protocol a review of staff personnel fees and the notes taken during the tour of the facility, the following determination have been established:
The Human Resources Administrator will not hire anyone who does not clear the background check. She contacts the Parrish Sheriff first and then she conducts a criminal background check through the FBI. The facility employment application has the three questions outlined in 115.317[e].
There have been 14 new hires and 1 new contact in the previous 12 months. There are seven other service providers on contract and they all have updated background checks. The facility's policy provided procedural guidelines for criminal background checks every five years. Staff personnel files were reviewed to verify current background checks.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The Moss Group conducted a Facility Sexual Safety Assessment onsite on October 31-November 1, 2012. A report was submitted and as a results the following actions were taken by RHFY:
Installation of a new camera system. The video monitoring system is comprised of cameras that are positioned throughout the various program areas. Cameras are visible. Residents and staff are made aware of the camera. In addition to the cameras, motion lights were installed inside and outside of the new school building. When anyone enters the school building, lights will come on and this will alert staff on duty.
The executive director now has the ability to monitor campus activities in real-time. The compliance officer has real-time monitoring from his office as well. The camera system can back-up films for 3 weeks.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY conducts administrative sexual abuse investigations ONLY; There is a MOU with the Alexandria Police – Juvenile Division, Child Welfare and the Child Welfare Licensing to conduct investigations as well, but the Alexandria Police conducts criminal investigations. The Auditors spoke to Chief Hay and Captain Terry via phone. They have a juvenile division. They have been train in a protocol for managing sexual assault victims. A female Detective is going to Dallas next month for additional training. RHFY has a MOU with the Alexandria Police and the MOU outlines the PREAA Standard 115.321 - A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,"
RHFY has a MOU in place with Christus St. Frances Cabrini Hospital for SANE (Sexual Assault Nurse Examiners) for forensic examinations. A MOU with Project Celebrations. I called the hospital and spoke to the Clinical Supervisor for the Emergency Room; he stated that there is never a time when a SANE will not conduct a forensic exam.
Auditor called to verify that this is a rape crisis hotline. The interview responses reflect/support the provision outlined in policy. Project Celebration and STAR are available crisis centers/services.
RHFY provides the residents access to both community-based services as well as qualified agency staff counseling. The boys' unit and girls' unit have a separate Social Worker/Counselor assigned to them. They are permitted to travel with youth to the hospital. Both SW/Counselors are Licensed MSW.
The verbiage of 115.321 (a-e) are outlined within the body of the MOUs with the Police and Rape Crisis Advocacy Center. Auditor reviewed copies of MOU's and the renewal.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The Agency has a policy, The Prison Rape Elimination Act, Section V, page 9, which directs all persons having knowledge of any child sexual abuse or sexual harassment to immediately report this to the proper authorities. All staffs are mandatory reporters. The policy is on the website.
Allegations of sexual abuse or sexual harassment are referred to the Department of Children and Family Services Child Protection Unit and Alexandria Police Department who have the legal authority to conduct criminal investigations. Referrals are documented. The Louisiana Child Welfare Licensing Division is notified because they are required by law to conduct an investigation as well. There is a MOU in place between RHFY and the Alexandria Police Department. The Auditor verified the MOU.
There were three (3) allegations reported to Child Protection and the Alexandria Police Department in the previous 12 months. The PREA Auditor received and reviewed the investigation packages on all three allegations.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:

The staff have participated in PREA training. The facility provided an outline that includes the eleven provisions outlined in 115.331(a). The training outlines do not compare to a comprehensive training curriculum. Staff signed a statement that they understand the training they received. The policy states that employees who are reassigned from the boys' house to the girls' house, or vice versa, receive additional training. The facility also has an outline for the "Refresher" course that is offered every two years. The auditor reviewed samples of the aforementioned documents. The newer employees' responses to the questions were sketchy and inconsistent and not as grounded as seasoned employees. The Training Coordinator stated that he no longer administers a post-test after the training. The implementation of a training curriculum will ensure consistent delivery of the information and ensures the same information is provided.
The PREA Auditor recommends the development and implementation of a comprehensive training curriculum. This may also require making adjustment to your PREA policy where needed.

RHFY consulted with PREA Resource Center during the corrective period and acquired comprehensive competency-based curriculums that have been approved as meeting the staff training provisions according to the eleven provisions outlined in 115.331(a). During the corrective action period, the curriculums were slightly modified to include specific RHFY information. A post test was reinstated. The Auditor also received and reviewed the new comprehensive competency-based curriculum, as well as the supporting training documents to verify that all staff have been training on the new curriculum.
RHFY policy was modified to accommodate the new curriculum. Staff sign a statement that they understand the training they received. The policy states that employees who are reassigned from the boys' house to the girls' house, or vice versa, receive additional training. The

facility also has an outline for the "Refresher" course that is offered every two years. This practice does not meet the standard requirement in 115.331(a).

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The facility has only one volunteer and her only role is to serve as an E/SSL Interpreter. The Auditor verified training documents and signed training acknowledgement that she has been trained on PREA. The service provider's contractors include, a physician, psychiatrist, barber, substance abuse counselor, independent living skills instructor, accreditation manager and dietician. Signed training acknowledgement were provided as well as an outline of the training. The volunteer, Sister Gloria Lewis, was also interviewed.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
During the Intake Process, direct care staff (female staff meet with female residents and male staff meets with male residents) meet with each resident and is responsible for educating his/her assigned residents about PREA. PREA Information is in the residents' handbook, policy book and PREA Book; resident signs an acknowledgment form that is retained in the resident's file.
Within 10 days of intake, the two program Supervisors (Male and Female) meets with the residents to ensure the residents get the comprehensive age appropriate PREA training. The SW also facilities groups with each youth on the PREA requirements. The PREA Auditor reviewed 10 residents' records to verify the intake training and follow training within 10 days.
Residents in need of specialized educational formats identified in 115.333[c-f] have not been admitted to RHFY within the previous 12 months.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff interviews according to the designated interview protocol, a discussion with the Alexandria Police Chief and the notes taken during the tour of the facility, the following determination have been established:
There is an MOU with the Alexandria Police Department to conduct criminal investigations. The MOU outlines PREA requirements in 115.334 (a-b). The Alexandria Police Department has a juvenile division and the officers have been trained in working with sexual assault victims. Auditor reviewed the MOU and spoke with the Alexandria Policy Chief.
RHFY administrative team conduct internal administrative investigations. The Executive Director (PCM), PREA Coordinator (Training Coordinator), HR Administrative and the Residential Program Manager completed the three hour PREA Investigating Sexual Abuse in a Confinement Setting presented by the National Institute of Corrections.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The medical staff at RHFY do not conduct forensic examinations. Forensic examinations are conducted by a local hospital. RHFY has a MOU with Christus St. Frances Cabrini Hospital for providing free SANE's/SAFE examinations. Auditor spoke to the Deputy Corner (MD) that oversee the nurses as well as the Director of Critical Care Services at the hospital.
In additional to the general PREA staff training, the Residential Service Manager(LCSW), the two MSW Licensed Social Workers and three nurses have competed the three-hour Behavioral Health Care for Sexually Assault Victims in Confinement Setting presented by the National Institute of Corrections. One of the social workers also has a LAFASA – Sexual Assault Certification. The auditor reviewed the staff licensures. RHFY also has a MOU in place with Project Celebration for crisis hotline services and counseling services free of charge to the residents. Project Celebration agrees to comply with Mandatory Child Abuse Reporting laws. The auditor also called the hotline to verify the services.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The Sexual Victimization Screening Instrument is only one part of a comprehensive assessment of a youth arriving at RHFY. A youth is monitored for 72 hours while he/she completes all instruments and information gathering interventions with staff. Residents sleeps in specially located bed during the first 72 hours. The initial screening considers history of Sex Abuse; gender identity; sexual aggression; hospitalization; medication; any diagnoses; drug use; family relation. The complete package also includes a medical screening, MH screening as well as Sexual Victimization.
All eleven (11) items that are outlined in PREA Standard 115.341 (c) are assessed in the Sexual Victimization Screening. The auditor reviewed a sample of the residents' intake information to verify compliance.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY does not utilize isolation. The housing units are not set up for a one bed isolation room, for some reason this is needed, the resident will be placed on a 1:1 supervision. The facility's management staff utilize all information obtained to help them make housing, bed and program assignment decisions as goal to ensure a safe environment for all residents. Residents who identify as bi-sexual stated that they have disclosed and that they feel very safe at RHFY. To date, RHFY has not admitted any residents that identifies as transgender of intersex.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY has policy to ensure that all provisions of the standard have been implemented to ensure the residents have access to multiple ways to safely and privately report allegations of sexual abuse, sexual harassment or retaliation. The residents and staff are aware, have access to and could verbalize the multiple ways to report, which included, but is not limited to staff, administration, children services, OJJ and/or the crisis hotlines. The numbers to the aforementioned resources are posted in the residents' housing, PREA notebook, Youth handbook, flyers and posters throughout the facility. The residents and staff all agree that RHFY is a sexually safe environment.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY has policy and administrative procedures for a residence grievance process. The residents, as well as their parents, a third party and/or staff may utilize the grievance process to report any allegation of sexual abuse, sexual harassment or retaliation. Residents receive information about the grievance process at Intake. All four elements delineated in PREA standard 115. 352(b) are outline in RHFYs PREA Policy and the grievance process is outlined in the resident' PREA Handbook. Residents sign an acknowledgement to verify that they received the grievance process information. Grievance boxes are located on the housing and the residents have unimpeded access to pencil and the grievance forms. No PREA related grievances or emergency grievances have been filed in the previous 12 months.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY administrative staff have several ways in which residents can 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 an incident. The residents may contact the following agencies by a phone call or in a written format. The phone number and address is provided for the Rape Crisis or Advocacy Center. This includes, but may not be limited to, the Office of Juvenile Justice the Child Abuse

Hotline
The staff and residents' response in the interviews supported the policy provisions and the information was posted throughout the living units and school and administration. Youth are provided this information in orientation, and the Client PREA Handbook; residents sign an acknowledgement to verify that they received the handbook. Youth have access to parents and legal guardians, and they can earn day leaves. Visiting hours are on Sunday's from 1:00PM to 4:00PM and take place in the juvenile's group home. Parents, grandparents, legal guardians, clergy, and lawyers are the only persons allowed to visit.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
Third parties may file reports of sexual abuse and sexual harassment on behalf of a resident. The information is outlined on RHFY website, youth handbook and on the group homes. If the resident declines to have the request processed on his or her behalf, the agency shall document the residents' decision.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The facility requires all staff to report immediately in accordance with Mandatory Child Abuse Reporting laws regarding any knowledge, suspicion or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff are required to preserve the confidentiality of the residents. All three elements in PREA Standard 115.361[e] are covered in the RHFY policy and is the responsibility of the Executive Director or designee.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The protection duties or RHFY are outline in the policies and procedures. To date, an incident of a resident being in imminent danger sexual abuse has not occurred.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
Policy provision for 115.363 have been outlined in RHFY PREA Policy. However, this issue has not occurred at RHFY.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The policy outlined all four elements PREA standard 115.364 (a). The allegation data for the previous 12 months is two (2). In both cases, the incidents occurred in the community. Forensic exams were not given due to the late reporting necessary timeline had passed.

The auditor reviewed the documentation, the notifications and the first Responders duties and implementation was according to policy.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY has a written institutional plan to coordinate actions to take in response to an incident of sexual abuse. The plan includes the actions for staff, first responders, medical and mental health practitioners, investigators, and facility leadership.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY does not have collective bargaining agreements. This standard is NON-APPLICABLE.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY's policies outline procedural guidelines for monitoring retaliation against residents and staff who report allegations of sexual abuse or cooperate with an investigation of sexual abuse or sexual harassment. A form was developed to capture the items to monitor as outlined in 115.367 [c] for at least 90 days. There has not been any reporting of retaliation during the previous 12 months. Residential Manager and Program Supervisors have been trained and are responsible for monitoring retaliation.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY does not use isolation and do not have segregation housing. There are no practices to assess because this has not been an issue.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
There is an MOU with the Alexandria Police Department to conduct criminal investigations. The MOU outlines PREA requirements in 115.334 (a-b). The Alexandria Police Department has a juvenile division that handles the crime scene in a juvenile program. The Alexandria Police Chief stated that the officers have been trained in working with sexual assault victims. Auditor reviewed the MOU and spoke with the Policy Chief.
RHFY administrative team conduct internal administrative investigations. The Executive Director (PCM), PREA Coordinator (Training Coordinator), HR Administrative and the Residential Program Manager completed the three hour PREA Investigating Sexual Abuse in a

Confinement Setting presented by the National Institute of Corrections.
RHFY receives written reports after each investigation. Sample of the investigation reports were reviewed. All notifications outlined to according to 115.371 in the policy in procedural guidelines. However, the provisions for 114.371 (c, e, h, I, j, k) and the MOU are not addressed in RHFY policy.

However, RHFY has revised the policy to incorporate the provisons for 114.371 (c, e, h, I, j, k). The MOU with the Alexandria Police Department has been incorporated into the policy as well. This practice currently meets the provisions outlined in PREA 115.371.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
Investigations reports were reviewed to assess whether the preponderance of evidence was present in the determining validity of an allegation.

Standard 115.373 Reporting to residents

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

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
There has not been any allegations of sexual abuse or sexual harassment toward any staff of RHFY.

Standard 115.376 Disciplinary sanctions for staff

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY's policy and training provides for disciplinary sanctions; however, there has not been any disciplinary sanctions imposed for sexual abuse or sexual harassment.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
Policy and procedural guidelines are provided. However, this has not occurred at RHFY.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY's policy and training provides for disciplinary sanctions. Qualified counseling services are available in house and in the community if needed. However, there has not been any disciplinary sanctions imposed for sexual abuse or sexual harassment.

Standard 115.381 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY medical and mental health counselors are very qualified licensed practitioners. Medical and Mental Health services are offered to all residents upon admission and throughout their stay in the group home. The residents that were sexually abused in the community were offered these services as well. The Auditor assessed nine residents' files and to verify that services were offered to the three residents that were sexually abused in the community. All residents at RHFY are under the age of 18.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY has a MOU with the local hospital and a victim advocacy organization, to ensure adequate resources are available when emergency medical and mental health services are needed. First Responders have been trained and a coordinated plan is available for staff to activate in case of an emergency. There was only one incident where emergency procedures were activated. The practice supports that policy. Residents may access community services while they are still at the group home.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
RHFY ensures that all residents receive medical and mental health services to meet their various needs. The victims and abusers are provided the best services available. The female victim receives the appropriate gender specific treatment. Follow up services and needs are incorporated into the residence's treatment plan during an individual session with his/her social worker.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☒ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
There were three investigations in the previous 12 months. Only one of the three had an incident review by administrative staff. An official form has been developed to capture the meeting content and discussion as outlined in PREA Standard 115.386 (d). The facility needs to conduct incident reviews of all investigations that are not determined to be unfounded.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The Office of Juvenile Justice publishes an Annual Report and RHFY submits all of its aggregated incident-based data to OJJ to include in the Annual Report. A copy of the report was reviewed by the auditor. There are no data concerns as the reporting of onsite allegations of sexual abuse or sexual harassment is zero. The allegations were made by the residents that occurred in the community.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The Office of Juvenile Justice publishes an Annual Report and RHFY submits all of its aggregated incident-based data to OJJ to include in the Annual Report. A copy of the report was reviewed by the auditor. There are no data concerns as the reporting of onsite allegations of sexual abuse or sexual harassment is zero. The allegations were made by the residents that occurred in the community.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on an analysis of the evidence, to include, but is not limited to a review of current policy or protocols, conducting staff and/or residents interviews according to the designated interview protocol and the notes taken during the tour of the facility, the following determination have been established:
The Office of Juvenile Justice publishes an Annual Report and RHFY submits all of its aggregated incident-based data to OJJ to include in the Annual Report. A copy of the report was reviewed by the auditor. There are no data concerns as the reporting of onsite allegations of sexual abuse or sexual harassment is zero. The allegations were made by the residents that occurred in the community. The website states that a copy of the report can be received upon request.

AUDITOR CERTIFICATION
I certify that:

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

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

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

requested in the report template.

Ida M. Lewis	November 25, 2016
Auditor Signature	Date