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

☐ **Interim** ☒ **Final**

Date of Report December 10, 2018

Auditor Information

Name: Lawrence J. Mahoney	**Email:** mahoneylj@live.com
Company Name: Mahoney and Associates, LLC	
Mailing Address: 6650 W. State St. #208	**City, State, Zip:** Wauwatosa, WI 53213
Telephone: 262-930-5334	**Date of Facility Visit:** **June 19-20, 2018**

Agency Information

Name of Agency: Lutheran Social Services of Wisconsin and Upper Michigan, Inc.		**Governing Authority or Parent Agency** *(If Applicable)*: Same	
Physical Address: 6737 W. Washington St. #2275		**City, State, Zip:** **West Allis, WI 53214**	
Mailing Address: SAA		**City, State, Zip:** Click or tap here to enter text.	
Telephone: 414-325-3015		**Is Agency accredited by any organization?** ☒ Yes ☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency mission: **Motivated by the compassion of Christ, we help people improve the quality of their lives.**

Agency Website with PREA Information: www.lsswis.org

Agency Chief Executive Officer

Name: **Hector Colon**	**Title:** President and Chief Executive Office
Email: Hector.Colon@lsswis.org	**Telephone:** 414-325-3015

Agency-Wide PREA Coordinator

Name: Laurie Lessard	**Title:** Director-ARJ-CCD Programs

Email: Laurie.Lessard@lsswis.org	**Telephone:** 715-456-5735
PREA Coordinator Reports to: Keith Lang	**Number of Compliance Managers who report to the PREA Coordinator 3**

Facility Information

Name of Facility: Affinity House			
Physical Address: 3042 Kilbourne Ave. Eau Claire, WI 54703			
Mailing Address (if different than above):			
Telephone Number: 715-833-0436			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Type:	☐ Community treatment center	☒ Halfway house	☐ Restitution center
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center	
	☐ Other community correctional facility		

Facility Mission: **Motivated by the compassion of Christ, we help people improve the quality of their lives.**

Facility Website with PREA Information: www.lsswis.org

Have there been any internal or external audits of and/or accreditations by any other organization? ☒ Yes ☐ No

Director

Name: Anita Kuster	**Title:** Program Supervisor
Email: Anita.Kuster@lsswis.org	**Telephone:** 715-833-0436

Facility PREA Compliance Manager

Name: Lynda Olson	**Title:** Program Manager
Email: Lynda.Olson@lsswis.org	**Telephone:** 715-833-0436

Facility Health Service Administrator

Name: NA	**Title:**
Email:	**Telephone:**

Facility Characteristics			
Designated Facility Capacity: 18	**Current Population of Facility:** 17		
Number of residents admitted to facility during the past 12 months			**76**
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			?
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			65
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			76
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	☒ Adults21-50 Click or tap here to enter text.	☐ Juveniles Click or tap here to enter text.	☐ Youthful residents Click or tap here to enter text.
Average length of stay or time under supervision:			75.8 days
Facility Security Level:			NA
Resident Custody Levels:			NA
Number of staff currently employed by the facility who may have contact with residents:			12
Number of staff hired by the facility during the past 12 months who may have contact with residents:			2
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			0

Physical Plant			
Number of Buildings: 1	**Number of Single Cell Housing Units:** 0		
Number of Multiple Occupancy Cell Housing Units:		0	
Number of Open Bay/Dorm Housing Units:		0	
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): **4 cameras: 2 exterior 2 interior. Interior cameras: front door and stairway. Monitor/control is locked in staff office. Recording capability for seven days.**			

Medical	
Type of Medical Facility: NA	
Forensic sexual assault medical exams are conducted at:	Sacred Heart Hospital, Eau Claire, WI

Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	0
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	5

Audit Findings

Audit Narrative

The agency received the Pre-audit Questionnaire and the Notice of Audit on May 3, 2018. The agency returned the questionnaire and supporting documents on June 12, 2018. Prior to the on-site visit, I reviewed the questionnaire and numerous documents. The on-site visit was scheduled for June 19-20, 2018. On June 12, 2018, I went to the Lutheran Social Services (LSS) corporate offices in West Allis, WI to review personnel files and interview the Human Capital Generalist for LSS residential halfway houses. I reviewed personnel files in order document criminal history checks, 5-year criminal history checks, and PREA training documentation for all staff.

The on-site visit of Affinity House occurred on June 19-20, 2018. I spent approximately 9 1/2 hours at the facility, interviewing staff and residents, reviewing resident files, and inspecting the physical facility. As mentioned above, I also spent time at the LSS corporate offices reviewing personnel files and interviewing the human resources staff.

I had previously conducted a PREA audit of Affinity in 2016. After a corrective action period of four months, the agency complied with all the applicable standards. I am very familiar with LSS halfway houses since I have conducted audits of five other LSS facilities since 2016. These audits include Fahrman Center in Eau Claire (2 audits), Wazee House in Black River Falls, Exodus House in Hudson, Cephas House in Waukesha, and Barron Area Residential Treatment Facility in Barronett. I am currently in the process of the second audit of Wazee House and I did the on-site visit of Wazee back-to-back with the Affinity House audit.

After arriving at Affinity House for the on-site visit, I interviewed the acting Program Manager, Brittany Nessel. Nessel is also the Program Manager for Wazee and Exodus. I interviewed Nessel as a designated PREA Investigator and as the staff member who is responsible for monitoring retaliation for both Affinity and Wazee. Nessel is also designated as the mental health professional and she was interviewed for those duties as well.

I toured the facility with the supervisor. I was able to view all rooms and areas of the facility. I observed the Notice of Audit and PREA information clearly posted in the facility. During interviews with staff and residents, I verified that the Notice was posted for several weeks.

During the on-site visit, I interviewed ten of the current seventeen residents. One of the residents interviewed had previously reported an incident of sexual harassment while she were at Affinity. I later reviewed documents from that investigation. I did not receive any correspondence from residents or staff prior to the on-site visit.

All staff at Affinity are female and the agency management said that they have never had male staff at the facility.

During the two days in the facility, I interviewed 10 of the 12 current staff members, including the Program Supervisor. Included in the interviews were staff members responsible for conducting intakes and PREA Risk Assessments, and the mental health professional. All staff are considered first responders. I was able to conduct all interviews in a private office. There are currently no interns or volunteers in the facility.

During the on-site visit, I reviewed the files for all 17 of the current residents to determine whether PREA information was provided at intake and risk assessments were completed. I also reviewed the files of 15 discharged residents. The discharged files included residents admitted from January 2017 to March 2018.

The facility has received two reports of sexual abuse or harassment in the past 12 months. I was able to review the results of those investigation reports. One occurred after four residents reporting that they were inappropriately touched or fondled by another resident. The agency investigated and determined that the allegations were substantiated. The other incident involved a current resident reporting (during her risk screening) that she had been sexually harassed by another resident while she was at Fahrman Center (another LSS facility) five years earlier. LSS provided me with copies of that investigation as well.

Following the on-site visit, I also conducted a telephone interview with Laurie Lessard, Director of Addictions/Restorative Justice, who is the PREA Coordinator for the agency. In addition to interviewing Lessard as the PREA Coordinator, I interviewed her as the CEO/Designee. I have interviewed Lessard several times during the previous LSS audits that I conducted.

As mentioned above, the previous audit of Affinity in 2016 resulted in corrective action for 16 standards. After a corrective action period of 4 months, the agency was able to comply with all applicable standards.

Facility Characteristics

Affinity House is licensed by the State of Wisconsin as a Community Based Residential Facility (CBRF) Halfway House. Its license classification is Class A ambulatory (AA). A class "A" ambulatory CBRF may serve only residents who are ambulatory and are mentally and physically capable of responding to an electronic fire alarm and exiting the facility without any help or verbal or physical prompting.

Affinity House is located in the City of Eau Claire, WI in a quiet, mostly residential area. The Program Manager reports no problems or concerns from the neighborhood. LSS opened the facility as an adolescent treatment program in 1988. Affinity House moved into the facility in 1992, after having operated at two previous locations in Eau Claire.

Affinity House has the capacity for 18 beds and serves female residents only. All residents are under the supervision of the Department of Corrections (DOC) and are on probation, parole, or extended supervision. LSS contracts with the DOC to operate Affinity House.

The primary program at Affinity is AODA programming, both primary and transitional treatment. Affinity offers other non-AODA programs that target criminogenic issues.

Affinity currently has twelve staff members, including the Program Supervisor. Two staff were recently hired. Affinity has a part-time Mental Health Specialist, who also is a Program Manager for two other facilities. In addition to the Supervisor, the staff members include 8 Support Professionals, 2 Alcohol and Drug Counselors, and Administrative Assistant. One of the regular staff members is also completing an internship at Affinity. Affinity has a contracted medical director who works in the facility, occasionally. The medical director primarily reviews medical records at intake and only occasionally sees residents.

The facility has three floors. The main floor has a living room, kitchen, dining room and staff office. The upper level has eight resident rooms with six double rooms and two single rooms. There are also two staff offices, two bathrooms, and two storage rooms on the upper level. The lower level has two resident rooms, both double bed rooms, two staff offices, laundry room, group room, two bathrooms and two storage rooms. Two of the resident rooms have extra beds for family visits that occasionally occur.

The facility is located on a large lot of approximately 2 acres and has several garages and storage sheds, used by LSS administration but are not accessible to Affinity staff or residents. There is a significant area for recreation areas behind the main building. All bathrooms for residents are private and residents are able to lock the doors while showering or using the bathroom.

The facility has four cameras for monitoring residents, two interior and two exterior. Staff are able to view the monitor in the staff office, centrally located on the main floor. The camera system is able to record up to 7 days, and can be maintained/stored for longer if needed. The facility previously had additional cameras, but the State of Wisconsin licensing staff directed that several cameras had to be disabled due to "clients' privacy rights. The State stated that the facility can't monitor residents in the living areas.

Summary of Audit Findings

Number of Standards Exceeded: 0

Number of Standards Met: 39

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

The interim report identified corrective action for 7 standards. The corrective action period was 5 months. The 7 standards that required corrective action were: **115.231**: Following corrective action, all staff have received PREA training and have signed training acknowledgments. **115.241**: Risk assessments and reassessments were reviewed for all residents admitted/discharged since the on-site visit. I reviewed assessments for 25 residents. The agency has demonstrated compliance by consistently completing all assessments and reassessments according to the timeframes identified in the standard. **115.252:** The Policy and Procedures, Notice to Residents, and Grievance Procedure were amended to reflect the agency policy to explicitly exclude the grievance process for reporting sexual abuse.**115.253**: PREA Notice to Residents has been amended regarding confidential support services. **115.261**: PREA PowerPoint-language was added regarding staff reporting requirements. **115.276** PREA PowerPoint was amended to include specifics regarding staff disciplinary sanctions. **115.283:** The Policy and Procedures and Notice to Residents were amended regarding on-going medical and mental health services to comply with the standards.

During the corrective action period, the agency provided sufficient documentation to establish that it complies with all applicable standards. LSS has consistently demonstrated its commitment to implementing PREA standards and protecting residents from sexual abuse and harassment.

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*)

Affinity House has PREA information posted in the facility. During the on-site visit, I observed PREA information posted on a bulletin board for residents. The board is located outside of the group room and the counselor's office and is visible to all residents.

LSS has a document titled LSS ARJ PREA Policy and Procedures that all staff receive upon hire. Interviews with 10 staff confirmed that these staff received this document. The PREA Policy and Procedure is also included in a PREA binder in the staff office area and is accessible to all staff. The PREA LSS Power Point, which all staff are required to review, includes the agency zero tolerance policy.

The PREA Policy and Procedure and the Notice to Residents describe the agency zero tolerance policy. The policy includes a description of the agency efforts to reduce and prevent abuse and harassment of residents. The policy includes definitions of prohibited behaviors and sanctions for staff and residents who participate in these behaviors.

As mentioned above, the agency amended both of these documents during previous audits in order to comply with the standards. During the on-site visit, I carefully reviewed these documents to ensure that the same documents are being used by the facility to comply with the standards.

All of the ten residents interviewed had a good awareness of PREA and were able to recite various ways to report sexual abuse or harassment.

All ten staff interviewed showed significant awareness of the agency zero tolerance policy and efforts to prevent, respond, report, and investigate sexual abuse and harassment. All staff reported that they received training on the agency's policies and procedures. All staff also said that the agency often does update training and reviews of PREA procedures during staffing and other meetings.

The LSS PREA Coordinator is Laurie Lessard, the Director of Addictions and Restorative Justice (ARJ). She has been the PREA Coordinator for over two years, but has been directly involved in implementing PREA standards for several years prior to becoming the PREA Coordinator. During the current audit of Affinity and during the previous five audits of LSS facilities, Lessard maintained regular contact with me. Lessard demonstrated that she is knowledgeable of PREA standards. Lessard has led several PREA investigations in the past 2 years. She has been engaged in the process of implementing PREA standards at Affinity House, as well as other LSS facilities. Since Lessard oversees all of the six halfway houses and answers directly to the Executive Director of ARJ/CCD programs, she able to effectively make changes in order to comply with PREA standards.

Based upon the interviews with staff, residents and the PREA Coordinator, along with my review of the PREA Policies and Procedures, Notice to Residents and PREA PowerPoint, I conclude that the agency complies with all aspects of the standards.

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 OR the response to 115.212(a)-1 is "NO".) ☐ 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*)

According to the PREA Coordinator and CEO Designee, the agency does not contract with any agency to house residents.

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 agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ 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

LSS contracts with the Department of Corrections to operate Affinity House. The contract with DOC requires at least one staff member to be present in the facility 24/7. As a licensed CBRF, Affinity is required to maintain at least one staff to supervise the facility at all times.

The Program Manager provided a copy of the staffing plan with the questionnaire. According to the questionnaire, the agency always complies with the staffing pattern. Support Professionals do the primary supervision of residents. During first shift, several staff are in the facility, including Support Professionals, Counselors, the Program Supervisor, and other support staff. Second shift may include some of the above staff, but there always one Support Professional working. One Support Professional usually works third shift and weekends. The staffing pattern is consistent with the size and layout of the facility and is consistent with other halfway houses of this size in Wisconsin.

Four cameras in the facility monitor the activities of the residents. There are 2 cameras the monitor the interior and 2 for the exterior. The facility previously had more cameras, but the State of Wisconsin licensing agency directed LSS to disable several cameras due to "clients' privacy rights". The two interior cameras monitor the front entrance way and stairwell.

Affinity staff said that they don't depend on the cameras to monitor resident activities. The camera system is older and the quality of monitors is somewhat poor. There are not "state of the art" options to pan, zoom, and tilt cameras. The video system normally records up to seven days, with longer retention as needed.

The questionnaire included the "ARJ Residential Program: Rounds/Bed Checks". Staff are required to make rounds and conduct room checks. The LSS policy states that staff "will make and document rounds and beds checks on a regular basis to assure both the whereabouts and safety of residents." The LSS policy states that staff "will make and document rounds and beds checks on a regular basis to assure both the whereabouts and safety of residents." During the "midnight shift", staff are required to do rounds/bed checks at midnight, 2 a.m. and 5 a.m. and must do one random check during the shift. Staff must check that cameras are operable and document that doors are locked at the specified time. Staff must document the rounds in a log.

During staff interviews, all staff said they were able to adequately monitor residents' activities considering the size and layout of the facility. All staff said that if something unusual occurred or if there was an incident, they could easily call additional to come in to provide assistance.

Both the PREA Coordinator and the Program Supervisor state that the agency reviews staffing patterns at least annually at Affinity and all of its facilities. The facility currently has twelve staff and usually operates at about that number of staff. Regarding staffing patters, the agency provided the following information: "All Supervisors meet with Managers and Director monthly either via web or in person. Changes to program offering or staffing needs are discussed. Individual programs review these items with Manager and/or Director when there is staff turnover or shortage, as well as annually when completing the required policy and procedure reviews, and quarterly when completing quarterly reports. "

During interviews, I asked residents if they feel safe at Affinity. All 10 residents interviewed stated that they feel safe at Affinity House and have sufficient privacy to change, shower, and toilet.

Based upon my review of the PREA Policy and Procedures, the facility-staffing pattern, notes from the on-site visit, that included a walk-thru of the entire facility, a review of the camera monitoring system, and interviews with the PREA Coordinator, Program Manager, ten staff, and ten residents, I conclude that the agency complies with the 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 X **NA -AGENCY POLICY PROHIBITS BODY SEARCHES OR PAT-DOWNS OF RESIDENTS UNDER ANY CIRCUMSTANCES.**

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 less than 50 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 less than 50 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 X **NA -AGENCY POLICY PROHIBITS BODY SEARCHES OR PAT-DOWNS OF RESIDENTS UNDER ANY CIRCUMSTANCES.**

- Does the facility document all cross-gender pat-down searches of female residents?
  ☐ Yes ☐ No X **NA -AGENCY POLICY PROHIBITS BODY SEARCHES OR PAT-DOWNS OF RESIDENTS UNDER ANY CIRCUMSTANCES.**

115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ 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 X **NA -AGENCY POLICY PROHIBITS BODY SEARCHES OR PAT-DOWNS OF RESIDENTS UNDER ANY CIRCUMSTANCES.**

- 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 X **NA -AGENCY POLICY PROHIBITS BODY SEARCHES OR PAT-DOWNS OF RESIDENTS UNDER ANY CIRCUMSTANCES.**

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

According to the Pre-Audit Questionnaire and interviews with LSS management staff, searches or pat down of residents are not allowed. The Affinity policy prohibits body searches or pat downs. No reports of body searches of any kind were reported by the agency in the past 12 months. During interviews, no staff reported conducting any body searches or pat-downs of residents. No residents reporting having a body search or pat-down.

Residents reported that they are able to shower, toilet, and change privately in several bathrooms located throughout the facility. The bathrooms have single toilets, sinks, and showers, and the doors to the bathrooms lock from the inside. All staff interviewed stated that residents have sufficient privacy in the facility. All staff at Affinity are female. No male staff have worked at the facility. As a result, there are no issues of cross-gender viewing of residents.

Since the facility prohibits all body searches and pat downs, the issue of searches of transgender or intersex residents is not applicable.

Based on my review of the PREA Policy and Procedures, the questionnaire, interviews with LSS management, 10 staff members and 11 residents, I conclude that the agency complies with all aspects of the 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 **Affinity House does not accept residents who are deaf or hard of hearing per State licensing guidelines.**

- 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 **Affinity House does not accept residents who are deaf or hard of hearing per State licensing guidelines.**

- 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 X **NA Affinity House does not accept residents who are deaf or hard of hearing per State licensing guidelines**.

- 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 X **NA Affinity House does not accept residents who are limited English proficient.**

- 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 **NA Affinity House does not accept residents who are blind or have low vision.**

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 **NA Affinity House does not accept residents who are limited English proficient.**

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☐ Yes ☐ No **NA Affinity House does not accept residents who are limited English proficient.**

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 **NA Affinity House does not accept residents who are limited English proficient.**

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

According to the PREA coordinator, Affinity does not accept clients with physical or most other disabilities. She cited several reasons for not accepting this population. As a Class "A" CBRF, the State of Wisconsin prohibits Affinity House from housing residents with physical disabilities. Residents must be ambulatory and must be mentally and physically able to respond to an electronic fire alarm and exiting the facility without any help or verbal or physical prompting. The facility may accept residents who may have learning disabilities or very low reading levels, if they are able to benefit from Affinity programs. Further, the facility does not accept clients who have limited English proficiency, deaf or hard of hearing, blind or low vision because the client would also not be able to participate and benefit from the programs.

LSS has a policy for providing PREA information to residents with disabilities or limited reading levels. According to the PREA Coordinator and the staff member who conducts intake, staff read the PREA handouts to residents and if they exhibited any reading limitations, extra time is spent reading the materials. All of the residents interviewed stated that intake staff gave them the PREA handouts and verbally explained the material to them. According to the LSS CEO/ Designee, any changes to this policy of not accepting clients with disabilities or with limited English proficiency would require significantly more resources and would put unreasonable burdens for them financially and administratively.

Based upon the agency policy to restrict residents with disabilities to those who can participate in programming, the services provided to those with learning disabilities and limited reading proficiency is sufficient for those residents to benefit from the agency efforts to prevent, detect, and respond to sexual assault and harassment.

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, or 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)

- Unless prohibited by law, 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

LSS has a "Background Check Policy and Procedure". I reviewed the policy with the LSS Human Capital Generalist. The policy states that background checks will be completed for all prospective and existing employees. It states that LSS prohibits the hiring or promotion of anyone who has contact with residents, and will not enlist the services of any contractor who may have contact with residents, who has engaged in sexual abuse in correctional facility, has been convicted, engaging, or attempting to engage in sexual activity in the community or has been civilly or administratively adjudicated to have engaged in the activity described in (a) (2) of 115.217.

The agency policy requires that the agency conduct background checks before enlisting the services of a contractor who may have contact with residents. The agency policy states that the agency will consider any incidents of sexual harassment in hiring or promotions, or to enlist the services of a contractor who may have contact with residents.

LSS conducts background checks on all prospective employees using **In Check**, which includes National Sex Offender Search, Wisconsin Sex Offender Registry, Wisconsin Dept. of Justice-CIB, and other states where the employee has been known to reside.

The LSS PREA Policy and Procedures states that LSS prohibits the hiring or promotion of who has contact with residents, and will not enlist the services of a contractor who: has engaged in sexual abuse in a correctional facility; has been convicted, engaging, or attempting to engage in sexual activity in the community, or has been civilly or administratively adjudicated to have engaged in the activity described in (2) (2) OF 115.27.

The LSS PREA Policy and Procedures states it will conduct that background checks before enlisting the services of contractors who may have contact with residents. It also states that material omissions of information pertaining to any form of sexual misconduct or the provision of materially false information at LSS programs is grounds for termination. LSS will ask all prospective employees in an interview whether they have been investigated or convicted of any types of sexual misconduct, sexual abuse or harassment. They also ask current employees the same questions during promotional exams.

The State of Wisconsin requires the agency to conduct caregiver background checks prior to hire and updated checks every four years.

On June 12, 2018, I visited the LSS corporate offices in West Allis. I met with the LSS Human Capital Generalist and reviewed personnel files for 12 current Affinity employees. Seven of the current employees were hired prior to the last audit in 2016 and the background checks for those staff was verified at that time. All employee files contained documentation that background checks were conducted prior to hire. The agency currently uses **In Check** for background checks, but has previously used Wisconsin Dept. of Justice-CIB, Due Diligence or HIRE RITE. LSS hired five of the existing employees more than five years prior to the audit. All five had criminal record/caregiver checks in 2015. The Caregiver checks are done every 4 years, which exceeds the five-year period required by the standard.

I also verified that the agency conducted a criminal background check on the contracted medical director.

Based upon my review of personnel records, PREA Policy and Procedures, LSS "Background Check Policy and Procedure," and interviews with the Human Capital Generalist, I conclude that the agency complies with all aspects of the standards.

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

According to LSS management, the agency has not made substantial expansions or modifications to existing facilities since the last audit. However, the agency opened a new halfway house in Barronett, WI in March 2017. The new facility included four cameras that monitor residents. The agency has consistently reviewed the use of cameras or other technology over the past several years. All of the LSS halfway houses have cameras. However, due to State of Wisconsin licensing requirements, the facilities were directed to disable several cameras due to "clients' privacy rights." As a result, the agency has had to rely less on cameras to monitor residents. Fortunately, Affinity is a small facility and relatively easy for staff to monitor resident activities.

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? ☒ Yes ☐ No

- 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 entity 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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☒ 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

According to the questionnaire and the PREA Coordinator, LSS is responsible for conducting administrative investigations of sexual abuse at Affinity House. The Eau Claire Police Department conducts criminal investigations. The Eau Claire Police Dept. has a specialized Sensitive Crimes Section and Crime Scenes Unit to gather evidence from crime scenes.

For administrative investigations, the PREA Policy and Procedures describes steps staff should take to preserve potential evidence. The policy describes the process for evidence protocol and forensic medical exams. There is sufficient detail in the procedure to aid investigators to obtain usable physical evidence. The policy gives staff specific instructions for handling evidence for incidents that occurred within 72 hours and incidents that occurred over 72 hours from report. All staff interviewed were aware of the facility process for obtaining usable physical evidence.

Affinity does not accept clients under the age of 18, so 115.221 (b) is not applicable.

The Pre-audit Questionnaire states that the facility offers victims of sexual assault access to forensic medical exams. The questionnaire states that Sacred Heart Hospital (SHH) in Eau Claire provides forensic medical exams. LSS has a MOU with SHH. I confirmed that SHH has Sexual Assault Nurse Examiners (SANEs), by accessing the hospital website. The Eau Claire County Victim/Witness Office also confirmed that SHH has SANEs who conducts forensic exams.

The PREA Policy and Procedures and PREA Notice to Residents state that victims will offered forensic medical exams, and "all necessary services" at no financial cost to the victim.

The PREA Policy and Procedures and Notice to Residents state that a victim advocate shall accompany the victim, if requested by the victim, through the forensic medical exam process and investigatory interviews, as well as provide emotional support, crisis intervention, information, and referrals.

LSS provided me with a copy of an updated Memorandum of Understanding (MOU) between LSS and Eau Claire County Victim Witness Program dated June 5, 2018.

On June 26, 2018, I contacted Jessica Bryan, Victim/Witness Coordinator for Eau Claire County. Bryan confirmed the information in the MOU, specifically that a member of their Crisis Support Team would accompany victims through the forensic medical exam process and interviews, and provide support services, information, and referrals for Affinity and Fahrman halfway houses. The Crisis Support Team members are trained in responding to sexual assault and forensic exams issues. The Crisis Support Team coordinates the use of SANEs and needed follow-up services for victims.

Affinity House also has a MOU with Bolton Refugee House who provide a victim advocate for the forensic medical exam process and for follow up interviews and supports services.

Based upon my review of the PREA Policy and Procedures, Notice to Residents, and interviews with the PREA Coordinator and Eau Claire County Victim Witness Coordinator, I conclude that the agency complies with all aspects of the standard.

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 such publication 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 questionnaire states that Affinity received 2 allegations of sexual abuse or harassment in the past 12 months. Affinity referred one complaint to the Eau Claire Police Department. LSS conducted administrative investigations for both complaints.

The LSS PREA Policy and Procedures and the Notice to Residents state that the agency will investigate reports of sexual abuse and harassment. The documents state that the agency shall report all incident so sexual abuse to law enforcement. The Eau Claire Police Department would conduct criminal investigations. The Policy and Procedure describes the responsibilities of LSS and law enforcement during an investigation.

The LSS website also states the same information regarding referrals to law enforcement. The website states that all reported incidents will investigated.

Based upon my review of the LSS Website, the PREA Policy and Procedures and the Notice to Residents, and interviews with the Program Manager and the PREA Coordinator, I conclude that the agency complies with the 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 juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ 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 PREA Policy and Procedures states "all staff and volunteers will receive training at hire and regular intervals throughout the year." "This training includes information on how to detect signs of abuse and how to effectively communicate with LGBTQ residents." The policy states that the Program Supervisor will provide PREA refresher training to include a review of policies, review of reporting forms, role plays related to handling a client compliant, etc." In addition to reviewing the PREA Policies and Procedures, staff are required to complete online training by reviewing PREA Power Point slides. The online training materials include a lengthy section for staff on ways to deal with female residents and specific information on responding to female victims of abuse.

All ten staff interviewed reported that they received PREA training. The eight staff hired since 2016 completed PREA training shortly after hire. Three staff hired prior to 2016 had PREA training between 2011 and 2016. According to the agency records, LSS first trained staff on in 2011. All staff interviewed reported that PREA and related updates were discussed at weekly in-service and staff meetings. All ten staff interviewed indicated a general awareness of PREA, the zero-tolerance policy, staff reporting procedures, and different ways that residents could report abuse. All staff at Affinity are considered first responders and during interviews, staff had appropriate responses to dealing with sexual abuse and harassment.

On June 12, 2018, I reviewed personnel files at the LSS administrative offices. The personnel files showed that 10 of the 12 current employees received initial PREA training between 2011-present. One new employee hired 5-31-18, has not completed the training. During the corrective action period, the agency provided documentation that the employee was trained. There was no record for training of another employee, but the agency reports that she resigned prior to receiving training. Regarding up-date training, six of the current staff have been employed at Affinity for over 2 years. Through interviews and file reviews, I was able to verify that they received two-year update training. The agency provided documents to show that all employees understand the training they have received through employee signature or electronic verification.

Based upon my review of the PREA Policy and Procedures, PREA PowerPoint slides, interviews with 10 staff, personnel file reviews of 12 staff, and training acknowledgments from all staff, I conclude that the agency complies with all aspects of the 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 LSS PREA Policy and Procedures states that volunteers, interns, and contractors will complete PREA training. Affinity currently has no interns or volunteers. Affinity has a contracted medical director. The agency provided me with a copy of the Medical Director's training record that showed he completed PREA training.

Based upon my review of training records and the PREA Policy and Procedures, I conclude that the agency complies with all aspects of the standard.

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 **X NA Affinity does not accept residents who are limited proficient.**
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☐ Yes ☒ No **X NA Affinity does not accept residents who are deaf.**
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☐ Yes ☐ No X **NA Affinity does not accept residents who are visually impaired.**
- 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 PREA "Notice to Residents" addresses the agency zero tolerance policy, how to report incidents, their right to be free of abuse and retaliation, and the agency response to reports of abuse or harassment. As mentioned earlier, Affinity does not accept clients who are limited English proficient, deaf, visually impaired or who have significant physical disabilities.

The LSS PREA Policy and Procedures state that staff will provide residents with the "PREA Notice to Residents" upon intake. All ten of the residents interviewed stated that they received PREA information in a packet upon arrival (all within 1-2 days). All residents said that staff explained the information to them. During the on-site visit, I reviewed the files for all current 17 residents. All files had signed acknowledgements from residents that they received PREA information upon intake. I also reviewed 10 files of discharged residents. These files included residents admitted from August 2016 to February 2018. All ten of the discharged files contained documentation that residents received PREA information upon intake.

I interviewed one of the staff members who is responsible for conducting intake at Affinity. She confirmed that all residents receive the PREA information upon arrival. She said that she explains the materials to the residents and if they have known disabilities or reading limitations, she will go over the materials in detail. The PREA Notice to Residents is contained in the Resident Handbook.

During the on-site visit, I observed printed PREA information posted in the facility. Information included names of victim support agencies with contacts/phone numbers for residents to report sexual abuse and harassment.

Based upon my review of the PREA Policy and Procedures, Notice to Residents, interviews with residents and staff, resident file reviews and observations during the on-site visit, I conclude that the agency complies with all aspects of the standard.

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 have received 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 PREA Policy and Procedures state that LSS has five designated investigators and that they are required to complete NIC PREA Training for Investigators. The five investigators are LSS Managers, including Laurie Lessard, the PREA Coordinator. All five completed NIC PREA Training for Investigators. LSS provided copies of the certificates from NIC.

I have interviewed Lessard several times during previous audits of LSS halfway houses. Lessard oversees all LSS halfway house PREA investigations.

During the on-site visit, I interviewed Brittany Nessel, the Program Manager, who is a designated investigator for LSS. Nessel have done seven PREA investigations in the past 2 years. She was able to describe the investigation process and is familiar with the standards.

Based upon my review of the PREA Policy and Procedures, NIC training certificates, and interviews with designated investigators, I conclude that the agency complies all aspects of the standards.

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? ☒ Yes ☐ No
- 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? ☒ Yes ☐ No
- 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? ☒ Yes ☐ No
- 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? ☒ Yes ☐ No

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 medical staff at the facility 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?
  ☒ Yes ☐ No

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☒ Yes ☐ No

- 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 for circumstances in which a particular status (employee or contractor/volunteer) does not apply.]
  ☒ 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 LSS PREA Policy and Procedures states that medical and mental health staff will receive training in 1) How to detect and access signs of sexual abuse and harassment, 2).How to preserve physical evidence 3) How to respond effectively and professionally to victims. 4) How and to whom to report allegations or suspicions. 5) How to effectively communicate with LGBTQI residents.

Affinity has a contracted medical director, and the agency provided documentation that the contractor has received training as described in (a).

Brittany Nessel, the Program Manager, is also the designated Mental Health Professional for Affinity. She stated that she completed PREA training as described in 115.231 and 235. The file review confirmed that she completed training. She also completed the other PREA training required of all staff.

Based upon my review of the PREA Policy and Procedures, agency training records, and interview with the Mental Health Professional, I conclude that the agency complies with all aspects of the standard.

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 PREA Policy and Procedures states that staff will screen residents for risk with 72 hours of intake and a reassessment shall be done not to exceed 30 days after arrival. The Pre-Audit Questionnaire states that the agency has a policy requiring screening for residents upon admission. The Case Manager/Counselor conducts the screenings. The policy states that no sanctions will be applied to residents who refuse to answer certain questions.

The agency uses the Sexual Vulnerability/Predation Risk Assessment. The policy includes language to require a re-assessment based on information described in 115.241 (g). The agency also has a separate policy for "Screening for Vulnerability/Aggression, which provides additional details for screening residents. The assessment considers all of the criteria listed in 115. 241.

During the on-site visit, I interviewed the AODA Counselor who is responsible for completing risk assessments. She completes the assessment with residents within 1-2 days of arrival. She schedules reassessments between days 22-29 of arrival. Residents with risk issues are staffed or a referral is made for services. If a resident was vulnerable the staff would determine the best room to place the residents and other factors. If needed, they could house a resident separate from others. While she would complete a reassessment based on a referral, incident of abuse, or other factors, she has not done so to date. The completed assessments are maintained in a locked drawer in the supervisor's office.

During the on-site visit, I reviewed completed risk assessments for all 17 current residents. All but one resident had an initial screening completed within three days. One resident has a screening completed in 4 days of arrival. I also reviewed all current residents for reassessments. Of the current residents, 10 were at the facility over 30 and

required reassessments. Of those 10 residents, 7 had reassessments completed within 30 days. The remaining 3 residents did not have reassessments completed within 30 days. These residents had reassessments done in 33 days, 31 days, and 31 days, which did not comply with the standard**.**

During the on-site visit, I also reviewed completed risk assessments for 15 discharged residents. These residents were admitted to the facility between April 2017 and May 2018. Fourteen of the residents had initial screens conduct with 72 hours. One resident was screened on the fifth day of arrival. Regarding reassessments, 14 of these residents remained in the facility for over 30 days and all 14 had reassessments completed within 30 days.

During the on-site visit, I interviewed 10 residents. All 10 reported said that staff asked them questions about their abuse history and risk issues after arrival. Four of the current residents who were interviewed had been admitted to the facility for more than 30 days. All four said that the follow–up screens were completed.

The agency's policies and procedures, and risk screening tool comply with the standards. However, as described in the interim report, the facility did not consistently complete initial assessments and reassessments for current residents according to the timeframes described in the standards.

In response to corrective action, the agency submitted of total of 44 assessments and reassessments for 25 residents who were admitted between June 26, 2018 and October 24, 2018. All initial assessments and reassessments were completed according to the time frames in the standards.

In summary, I reviewed completed risk assessments and reassessments for the 17 residents admitted at the time of the on-site visit, 15 discharged residents, and 25 residents admitted over 5 months since the on-site visit.

Based on my review of the PREA Policies and Procedures, the Sexual Vulnerability/Predation Risk Assessment, interviews with 10 residents and the staff member responsible for completing risk screening, and completed assessments for 57 current and discharged residents, I conclude that the agency complies with all aspects of the standards

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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ 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 LSS ARJ PREA Policy and Procedures addresses the use of risk screening. "Room assignments and general program participation will be predicated on the findings of the assessment. Room assignments are decided by clinical staff and LGBTQI residents will never be assigned to a room solely on their identification as LGBTI. Additionally, information from risk screening tool will be included in room assignment decisions for all residents."

During the on-site visit, I interviewed the AODA Counselor who is responsible for completing screening. She said that when residents have risk issues, a staffing is completed, usually within a couple of days. They would consider options for housing the resident within the facility and ways to best keep the resident safe. She said they would alert all staff about whether a resident was at risk or posed a risk to others. The counselor said that she offers residents resources and encourages them to use the resources offered. During my review of the completed assessments, I noted that all completed assessments had comments about the resident's risk and with recommendations noted.

During the assessment, staff ask transgender or intersex residents about their own views of their safety and the facility gives the residents response serious consideration. All residents at Affinity are allowed to shower separately from other residents, so 115.242 (e) is not an issue.

Based upon my review of the agency policies and procedures and interviews with the AODA Counselor, I conclude that the agency complies with all aspects of the 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*)

The PREA Notice to Residents states that residents can report sexual abuse "verbally, in writing, anonymously, or by a third party". It also states that residents may tell any staff member, tell their probation/parole agent, contact the Manager for Affinity House, or the LSS PREA Coordinator, the Director of Addictions and Restorative Justice. It also states that they may send a letter to the Department of Corrections PREA Director or contact law enforcement by calling 911. The PREA Policy and Procedures state that residents may report abuse "verbally, in writing, anonymously, or by a third party" and lists the same contacts listed above in the Notice to Residents.

During the on-site visit, I interviewed ten of the current 17 residents. One of the residents interviewed had previously made a complaint of sexual abuse. All residents interviewed were aware of different ways to report. While most residents said they would contact a staff member, others cited the police and counselors as someone they could contact. All residents were aware that they could report abuse third party.

During the on-site visit, I interviewed 10 staff members. All staff interviewed were aware of multiple reporting options for residents. All staff said they would immediately document verbal reports of abuse or harassment.

The PREA Policy and Procedures states that staff shall accept all reports of sexual abuse from clients made verbally, in writing, anonymously, and from third parties and shall document any reports.

The PREA Policy and Procedures lists methods for staff to privately report sexual abuse and harassment of residents as described in 115.251 (d). "Staff may utilize any of the reporting methods contained within the Notice to Residents-PREA form to report any incident of sexual harassment or abuse and may make the report privately."

Based upon my review of the PREA Notice to Residents and PREA Policy and Procedure, along with interviews with 10 staff and 10 residents, I conclude that the agency complies with all aspects of the 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 ☒ NA

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*)

In an interview with the Program Manager, she said that LSS recently amended its grievance policy. She stated that the grievance procedure may not be used by residents and that the agency will no longer have an administrative process to address sexual abuse. They reasoned that there are of number of other ways for residents to report sexual abuse or harassment and that using the previous grievance process would not ensure better reporting or response to reports of abuse. LSS immediately responds to complaints of sexual abuse or harassments and the filing of a grievance would not improve the agency response to better protect residents. The PREA Coordinator confirmed that agency management addresses the grievance issue and decided to make the change at all LSS halfway houses.

Because the policy change is recent, the PREA Policy and Procedures, LSS Grievance Resolution Process, and the Notice to Residents have not been amended to address the change in policy at the time of the on-site visit. As a result, corrective action was required.

In response to corrective action, the agency amended the PREA Policy and Procedures, LSS Grievance Resolution Process, and the PREA Notice to Residents to address the recent change in policy. Specifically, all three documents state that the LSS Grievance Resolution Process shall not be used as an administrative remedy process to address sexual abuse.

Based upon my interview with the Program Manager and my review of the PREA Policy and Procedures, Notice to Residents and the Grievance Resolution Process, I conclude that the agency is exempt from the standards.

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*)

The Questionnaire states that Affinity has agreements with agencies to provide residents with emotional support services. The PREA Notice to Residents lists a number of victim advocacy services, with addresses and phone numbers that includes Eau Claire County Victim/Witness Services, Bolton Refuge House, Family Support Center, and Vantage Point Clinic. This information is also posted in the facility.

The Notice to Residents initially did not address 115.253 (a) to state they will enable "reasonable communication between residents and those organizations, in as confidential manner as possible," but was amended as part of corrective action. The Notice to Residents did not fully address (b), but it has also been amended as part of corrective action.

The PREA Policy and Procedures addresses (a) regarding reasonable communication between residents and organizations and confidentiality. The Policy and Procedures did not fully address (b), but it has been amended as part of corrective action.

Affinity House has Inter-Agency agreements with Eau Claire County Victim/Witness Services and Bolton Refuge House in which these community service providers agree to provide residents with confidential emotional support services related to sexual abuse. Both agreements were signed shortly before the on-site visit. Affinity had previous agreements with these agencies in 2016. On June 26, 2018, I contacted Jessica Bryan, Victim/Witness Coordinator for Eau Claire County. Bryan confirmed the information in the agreement.

During the on-site visit, I observed the names and telephone numbers of several community based agencies posted in the facility.

As part of corrective action, the agency has amended the PREA Notice to Residents to state they will enable "reasonable communication between residents and those organizations, in as confidential manner as possible." The agency also amended the PREA Notice to Residents and the PREA Policies and Procedures, to inform residents of the extent to which such communications between residents and support service organizations will be monitored.

Based upon my review of the amended Policy and Procedures and Notice to Residents, along with the Inter-agency agreements with Eau Claire County Victim/Witness Services and Bolton Refuge House, I conclude that the agency complies with all aspects of the standards.

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*)

The PREA Policy and Procedures, Notice to Residents, and the LSS website all state that reports can be accepted from a third party and all three documents list agency contacts to receive reports. During the on-site visit, I observed information regarding third-party reporting that was posted in the facility. As a result, the agency complies with all aspects of the standard.

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*)

The PREA Policy and Procedures states that staff are required to report any knowledge, suspicion, or information they receive regarding sexual abuse or harassment, whether it occurred at Affinity or another facility. The policy also mandates reporting of retaliation against residents and staff. The policy also states that staff are to report any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The LSS Employee Handbook has several references that make it clear that employees have a duty to warn. The PREA Policy prohibits staff from revealing information related to a sexual abuse other than reasons cited in 115.261 (b).

The PREA PowerPoint, which all staff are required to review, did not specifically state that staff are required to report any knowledge, suspicion, or information they receive regarding sexual abuse or harassment.

During the on-site visit, I interviewed 10 Affinity staff. All staff interviewed said that they are required to report any knowledge, suspicion, or information they receive regarding abuse. One of the staff members interviewed received a report of sexual abuse. She immediately reported the complaint to management and the matter was quickly investigated.

The Policy and Procedures has a statement regarding mandatory reporting described in 115.261 (c). The facility does not accept residents under the age of 18, so (d) is not applicable.

The LSS PREA Policy and Procedures has several statements that requires the facility to report all allegations of sexual abuse and sexual harassment to the designated investigators.

In response to corrective action, the agency amended the PREA PowerPoint training to include a specific statement that staff are required to report any knowledge, suspicion, or information they receive regarding sexual abuse or harassment.

Based upon my review of the Policy and Procedures and the PREA PowerPoint and interviews with 10 staff, I conclude that the agency complies with all aspects of the standards.

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*)

The PREA Policy and Procedures states that if a staff become aware of the potential of an imminent sexual assault on a client or observe a sexual assault taking place within the facility, a number of steps will be taken immediately, including calling 911, notifying the supervisor, provide victim or intended victim with safety until perpetrator is removed. There are number of other steps addressed in the policy that indicates the staff immediate response. Staff are also referred to the First Responder section of the policy for further steps. The PREA Power Point, used for staff training, has similar language for dealing with imminent risk.

According to the Pre-Audit Questionnaire, Affinity has had no instances in the past 12 months where a resident was subject to a substantial risk.

During the on-site visit, I interviewed 10 staff and asked them how they would respond to imminent risk. All staff said they would consider the victim's safety as a priority and all ten were familiar with the Policy and Procedures for steps to take if someone was at risk. The Program Manager and Program Supervisor also responded to ways the facility responds to imminent risk.

Based upon interviews with 10 Affinity staff, the Program Manager, and Program Supervisor, and a review of the PREA Policy and Procedures and PREA Power Point training slides, I conclude that the agency complies with all aspects of the standard.

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*)

The PREA Policy and Procedures addresses the issue of reporting to other facilities when a resident reports abuse from other facilities and include the following statement: "Upon receiving an allegation that sexually abusive behavior occurred at another confinement facility or correctional agency, the Program Supervisor, will report the allegation to the head of the facility where the incident occurred. Notification will be provided within 72 hours of receipt of the allegation and will document that they provided such notification."

In the past year, there was an incident in which an Affinity House resident reported that she was sexually harassed at Fahrman Center (another LSS halfway house) approximately 5 years earlier. According to the PREA Coordinator, the incident was immediately reported to her by the Program Manager and the matter was investigated.

The language in the PREA Policy and Procedures complies with the standard.

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*)

The agency addresses first responder duties in the PREA Policy and Procedures. All Affinity staff are first responders. The policy lists steps to take upon receiving a report of abuse, including: staff will assist the client in making a report, maintain confidentiality, provide emotional support to the client, call the supervisor, call 911 (depending on situation), preserve evidence/gather evidence, and contact victim support services. The PREA Power Point also refers to first responder duties.

During the on-site visit, I interviewed 10 of the Affinity staff. All staff consistently the policy when asked what steps they would take if they became aware of an assault. All responses included protecting the victim, separating the victim from the abuser, calling 911, contacting the supervisor, preserving physical evidence, documenting the incident, and calling in additional staff for assistance.

Affinity received one report of sexual abuse that occurred at the facility in the past 12 months. The incident involved four residents reporting that another resident inappropriately touched and fondled them. Two of the victims reported the assaults to the Alcohol and Drug Counselor, who immediately reported it to Laurie Lessard, the PREA Coordinator/ARJ Director. Lessard instructed the counselor to have the offender removed from the program and placed in custody by the Department of Corrections. The reports from the incident indicated that the perpetrator was removed from the program within an hour of the report being received. The Eau Claire Police Department was notified by LSS and both agencies conducted investigations of the matter.

During the on-site visit, I interviewed one of the victims who initially reported the incident. The other victims were no longer in the program at the time of the on-site visit. During the interview, the resident stated that she believed the Affinity staff handled the situation appropriately. Regarding the perpetrator, the resident said, "She was gone right away." The resident said she was notified of the outcome and that Affinity staff offered her services.

Based upon my review of the PREA Policy and Procedures, the Power Point training slides, investigation reports and interviews with the PREA Coordinator, Program Manager, Program Supervisor, resident/victim and 10 Affinity staff, I conclude that the agency complies with all aspects of the standard.

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*)

The PREA Policy and Procedures addresses the staff response to an incident of abuse. The policy lists responsibilities of first responder staff, the program manager, program supervisor, PREA Coordinator, and counseling staff.

The PREA Power Point training also addresses how staff shall respond to reports of abuse or harassment. Based upon my review of the Policy and Procedures, I conclude that the agency complies with the standard.

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 **X NA LSS has not collective bargaining agreements at any of its facilities.**

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*)

According to the Pre-Audit Questionnaire and interviews with LSS management staff, Affinity has no collective bargaining agreements.

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*)

The PREA Policy and Procedures addresses protection against retaliation. The policy states that retaliation can include staff on staff, staff on resident, resident on resident, and resident on staff. LSS has designated the Program Supervisor and Program Manager to monitor retaliation. Retaliation is monitored for 90 days, or longer, if needed. Monitoring includes daily review of staff log, daily check-in with staff, and ongoing check-in with the reporting resident. The policy identified various protection measures including change in room assignment, change to another facility for either the resident experiencing retaliation or the resident who is retaliating. The policy states that services will be provided to staff or residents who are being retaliated. The policy states that residents and staff may report retaliation verbally, in writing, anonymously, or by third party. Reports of retaliation must be reported to the supervisor, PREA Coordinator, or program manager.

LSS has a "Whistleblower Policy". This Policy addresses retaliation by a staff member who retaliates against "someone who has reported a concern, in good faith" is subject to discipline, including dismissal.

The PREA Notice to Residents, provided to all residents at intake, defines and prohibits retaliation, and gives reporting options for residents. The LSS Power Point training contains detailed information about retaliation.

During the on-site visit, I interviewed Brittany Nessel, the acting Program Manager is responsible for monitoring retaliation along with the Program Supervisor. I interviewed Nessel using the "Monitoring Retaliation" protocol questions. Nessel said that she would primarily direct the supervisor to do the day-to-day monitoring and "coach them" on the process. She identified several steps she would take to monitor retaliation such as increased rounds, and bringing in additional staff if needed. Regular checks with the victim would occur. If a staff member were retaliating, suspension or dismissal would likely be an option. Residents found to be retaliation would be removed from the program.

Other steps would include talking to staff about concerns, monitoring different shifts, review video cameras. She would "pop in on the weekend or evening" occasionally to monitor the situation is appropriate. The facility would monitor a resident who is subject to retaliation for as long as the resident was at Affinity. After discharge they would also information the Probation and Parole Agent that the resident may be subject to retaliation.

The CEO Designee/ PREA Coordinator, Laurie Lessard was also asked how the agency protects staff and residents from retaliation. She listed several steps that the agency would take to deal with retaliation.

Based upon my review of the PREA Policy and Procedures, PREA Notice to Residents, PREA power point slides, and interviews with the Program Manager and PREA Coordinator, I conclude that the agency complies with all aspects of the standards.

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*)

LSS PREA Policy and Procedures has a lengthy section on how the agency shall conducts investigations. In summary, it includes the following information: LSS policy states that an investigation will begin immediately, with the investigation team to consist of at least two investigators. LSS conducts administrative investigations only. Criminal allegations will be referred to law enforcement with report filed. Agency and counseling staff assume responsibility for services for the victim. If allegations involve a staff member, the staff member will be immediately placed on administrative leave. The team will begin conducting interviews within 3-5 business days. Decisions made about referrals for criminal charges will be based on the preponderance of evidence. The PREA Coordinator will be involved in all decisions. Supervisor or Manager will maintain contact with law enforcement and are updated on administrative investigation. Supervisor or manager will remain in contact with law enforcement to keep up to date on the criminal investigation. Residents will be informed as to the outcome (described per the standard). The policy also states that written reports will be retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, and that the departure of the alleged abuser or victim from the facility shall not provide a basis for terminating an investigation.

The Policy and Procedures also states that DOC will make the determination regarding the abusers discipline, with input from the administrative and criminal investigation. Any staff found to be engaged in sexual harassment or abuse will be terminated. LSS will retain client files for 10 years when there is a PREA investigation. After 30 days after the PREA case has been closed, investigative team and program leadership will meet to review and discuss any strategies or changes to operations or policies to prevent suture situations.

LSS has five managers who are designated PREA investigators. All five have completed the NIC PREA Investigator training. During the on-site visit, I interviewed Brittany Nessel, the acting Program Manager, who one of the designated investigators using the interview protocols for investigative staff. I reviewed the process with the Program Manager and she confirmed that the above policy is followed. She was able to recite the various steps in conducting investigations. The agency would notify law enforcement if a compelled interview were needed. The agency also consider a victim's credibility on an individual basis, not on the person's status as a resident. The agency policy prohibits the use of polygraph or other truth-telling devices.

The Program Manager stated the she has been involved in in several investigations at LSS facilities over the past couple of years. Most investigations have been completed within 48-72 hours. Affinity had one investigation of sexual abuse in the past year. Nessel was involved in that investigation which was initiated after four residents reported that they were inappropriately touch or fondled by another resident.

I reviewed copies of the investigation materials from this incident which occurred in April 2018. The packet that I reviewed included a PREA Investigation Checklist, with specific task assigned to investigators and staff. The incident was reported to a counselor, who immediately contact the ARJ Director/PREA Coordinator. The resident who was alleged to have touched the other residents was immediately removed from the program and placed in custody. The Eau Claire Police Department (ECPD) was notified and both agencies immediately started investigations.

Within 24 hours, LSS investigators began interviewing victims and possible witnesses. The perpetrator was interviewed in the jail within four days. The ECPD also interviewed victims and the perpetrator and their forwarded reports to LSS. LSS investigators maintained contact with ECPD during the investigation. ECPD referred the case to the District Attorney for criminal charges. The agency determined that the allegations were substantiated and cited several factors in the decision. Shortly after the investigation was completed, LSS reviewed the facts of the case and included an effort to determine whether staff actions or failures to act contributed to the abuse. Based upon my review of the investigative reports, it is my opinion that the agency conducted a thorough investigation and followed PREA standards throughout.

Based upon my review of the PREA Policy and Procedures, interview with a LSS investigator, and investigative reports from an incident of sexual abuse, I conclude that the agency complies with all aspects of the standard.

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*)

According to the agency PREA Coordinator and designated investigator, LSS uses "a preponderance of evidence" in determining whether allegations of sexual abuse or harassment are substantiated. This standard is identified in the PREA Policy and Procedures.

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 an agency 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*)

The PREA Notice to Residents, and PREA Policy and Procedures includes information that residents will be informed on the outcome, whether the allegation is substantiated, unsubstantiated, or unfounded. The Policy and Notice to Residents state that it will inform the residents as to the status (indictment) or disposition of the criminal investigation. It also states that the Program Supervisor or Program Manager will remain in contact with law enforcement in order to remain abreast of any criminal investigation.

If a staff member is the subject of an allegation, the Policy requires that residents be informed whether the staff has been placed on leave or no longer an employee of the agency, and the disposition and outcome of any indictments or convictions from the criminal investigation. The policy states that such notification will be documented in the client chart.

As mentioned earlier, Affinity House received one allegation of sexual abuse in the past 12 months. After the matter was investigated, letters were sent to four victims advising them that the allegations were found to be substantiated. LSS forwarded copies of the letters to me. The letters referenced the status of the ECPD investigation.

Based upon my review of the PREA Notice to Residents, the PREA Policy and Procedures and recent letters sent to victims, I conclude that the agency complies with all aspects of the standard.

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*)

The PREA Policy and Procedures addresses sanctions for staff. The Policy states that sanctions for staff who violate agency sexual abuse policies relating to sexual abuse and harassment (other than actually engaging in sexual abuse), shall be commensurate with the nature and circumstances of the act committed, the staff member's disciplinary history, and the sanction imposed for comparable offenses by other staff with similar histories.

Commented [A1]:

The LSS Employee Handbook addresses disciplinary action for staff who violate harassment rules. The Handbook has a section on harassment and states "Employees found in violation of the harassment policy are subject to disciplinary action up to and including separation from employment, depending on the facts and severity of the incident. "

The PREA PowerPoint, which all staff are required to review, did not address disciplinary sanctions for staff who violate sexual abuse or sexual harassment policies. However, in response to corrective action, the agency amended the PREA PowerPoint to state "Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Based upon my review of the PREA PowerPoint, employee handbook, and PREA Policy and Procedures, I conclude that the agency complies with all aspects of the standards.

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*)

The PREA Policy and Procedures states, "Contractors and/or volunteer found to have engaged in sexual harassment, sexual misconduct, sexual abuse will be dismissed from services at any LSS ARJ facility." Affinity has one contracted staff, the medical director. According to the Program Manager, the medical director has limited contract with residents and primarily reviews intake medical records. Affinity currently has no interns or volunteers.

In the past 12 months, no contractor or volunteer have been reported to law enforcement or licensing bodies for sexual abuse. The CEO Designee/PREA Coordinator said that any contractor, intern, or volunteer that violated agency policies would be terminated, so no remedial measures would be taken. Based upon the agency policy and the interviews with LSS management, the agency complies with the standard.

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 **X NA Facility does not offer such interventions.**

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)

- 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*)

According to the PREA Coordinator, LSS has no authority to sanction residents who engage in sexual abuse or harassment. The decision would lie with the Department of Corrections (DOC). The LSS Policy and Procedure states that offending residents would be immediately removed from the program if they engage in sexual abuse or harassment. DOC would detain the resident pending their investigation and disposition. DOC would determine the actual sanction. Residents who are under supervision with DOC are afforded due process rights, including an administrative hearing. From my experience working for DOC, I am aware of the due process afforded offenders. DOC guidelines require the agency to determine 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. It would also consider the resident's mental illness before determining a disposition.

Regarding 115.278 (f), the discipline determination would also be made by DOC. DOC follows PREA standards regarding false reporting and would not discipline a resident if it was determined that a report was made in good faith even if the investigation does not establish sufficient evidence to substantiate the allegation.

According to the Pre-Audit Questionnaire, Affinity prohibits all sexual activity between residents. The agency would only deem such activity to constitute sexual abuse if the activity was coerced. The questionnaire also states that the facility does not offer therapy, counseling or intervention to address underlying reasons for sexual abuse.

Based upon my review of the PREA Policy and Procedures and interview with the PREA Coordinator, the agency complies with the 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*)

The PREA Policy and Procedures, and the PREA Notice to Residents state that resident victims shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The documents state, "Victims shall receive information and access to emergency contraception, testing for and treatment of sexually transmitted infections, including HIV, and prophylaxis at no cost to the resident. All necessary services will be provided to the resident victim as no cost, regardless of whether the victim names an abuser or cooperates with the investigation." The Policy and Procedures also state "The facility shall provide such victims with medical and mental health care consistent with the community level of care."

The PREA Policy and Procedures states that first responder staff shall take steps to protect the victim and shall notify the appropriate medical and mental health practitioners. Typically, there are no medical or mental health practitioners on duty at Affinity.

Following the recent investigation of sexual abuse at Affinity, four residents were offered intervention services.

Based upon my review of the PREA Policy and Procedures and the PREA Notice to Residents, I conclude that the agency complies with all aspects of the standard.

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.) ☒ 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.) ☒ 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*)

LSS has Inter-Agency Agreements for on-going medical and mental health treatment for resident victims. During the on-site visit, I observed information about these resources posted in the facility.

The PREA Policy and Procedures and Notice to Residents state that residents will have access to medical and mental health evaluation and follow-up care, including screening for infectious disease, HIV, viral hepatitis, or other sexually transmitted infections, pregnancy testing, and administration of prophylactic medication at no cost to the victim. It also states that the facility will coordinate referrals to mental health providers in the community for follow-up care, also at no cost to the resident. The policy states that evaluation and treatment of such victims shall "include referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody." It states that the facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners (h).

The policy states that evaluation and treatment for such victims shall "include, as appropriate follow up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody," to comply with (b). The policy states that the facility shall provide such victims with medical and mental health care services "consistent with the community level of care." (c).

The Policy and Procedures states that residents will be offered 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. However, the PREA Notice to Residents did not contain such information. In addition, neither the Policy and Procedures or the Notice to Residents contained information stating that if pregnancy results from the conduct described in paragraph § 115.283(d), victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

In response to corrective action, the agency amended the Policy and Procedures and Notice to Residents to state: "If pregnancy results from the conduct described in paragraph § 115.283(d), such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. The agency also amended the PREA Notice to Residents to state: "Residents will be offered 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."

Based upon my review of the Policy and Procedure, Notice to Residents and Inter-agency agreements, I conclude that the agency complies with all aspects of the standards.

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*)

The PREA Policy and Procedures addresses sexual abuse incident reviews. The policy includes a review of unsubstantiated and substantiated allegations by the executive staff in order to assess the facility's response to the allegations. The team shall meet within 30 days of the conclusion of the investigation. The policy identifies the members of the review team that includes upper management. All factors in 115.286 (d) are considered in the agency review.

The policy states that the team shall review whether allegations were motivated by race, ethnicity, gender identity; lesbian gay, bisexual, transgender, or intersex identification, status, or gang affiliation; or was motivated by other dynamics at the facility. The review team shall examine the area of the facility where the incident occurred to assess if physical barriers in the area enable abuse. The team reviews staffing levels and monitoring technology. The team prepares a report of its finding and makes recommendations for improvement to the facility head the PREA Compliance Manager.

The policy states that the area of the facility where the incident occurred will be examined and whether monitoring technology should be augmented. The incident review also requires a report of its findings to include recommendations and implement the recommendation or document its reasons for not doing so. The facility shall implement the recommendations, or it shall document reasons for not doing so.

Following a recent investigation of sexual abuse at Affinity House, LSS held an incident review within one week of completing the investigation. I was provided a copy of the review. The allegation in the matter was substantiated by the investigators. The review team included the ARJ Director/PREA Coordinator, Program Supervisor, Program Manager, and Human Capital Generalist. Staffing levels were reviewed and other factors. Since the incidents occurred during a program group, group protocols were reviewed and revised. The agency also determined that the supervisor will review all PREA information with residents and information about personal boundaries.

Based upon my review of the PREA Policy and Procedures and an incident review dated 5/9/18, I conclude that the agency complies with all aspects of the standards.

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*)

The Questionnaire states that the agency collects data for all allegations of sexual abuse at its facilities. The PREA Policy and Procedures, state that following an incident, data shall be collected on a "Significant Events Reporting Form" along with data from the "ARJ Demographic and Outcome Measurement Form". The data collected complies with the standard and includes data necessary to answer all questions from the most recent Survey of Sexual Violence conducted by the DOJ. The PREA policy states that these documents shall be stored electronically.

Based upon my review of the PREA Policy and Procedures, the "Significant Events Reporting Form", and the "ARJ Demographic and Outcome Measurement Form", I conclude that the agency complies with all aspects of the standard.

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*)

In 2015, LSS began reviewing data from all of its facilities to identify problem areas, taking corrective action on an ongoing basis, and prepare an annual report of its finding per 115.288 (a)-1. According to the PREA Coordinator, LSS collects sexual abuse incident data and reviews the data.

LSS has published three annual PREA reports since 2015. The most recent report, published on the agency website, was for calendar year 2017. The report includes data from five LSS halfway houses. (The agency opened a new halfway house in 2017.) The report stated that its facilities had 2 substantiated incidents of sexual harassment and one unfounded report of sexual harassment in 2017. I reviewed the annual reports on the LSS website. The report identifies the agency response to incidents, specifically at Fahrman Center. The changes at Fahrman Center included changing procedures to further separate male and female residents and changes to recreation activities. The report also noted that all five facilities comply with PREA standards. The annual report was approved by Laurie Lessard, Director of Addictions/Restorative Justice.

The PREA Policy and Procedures states that the agency will annually review incidents and identify problem areas, taking corrective action on an on-going basis, and preparing an annual report.

Based upon my review of the agency website, PREA Policy and Procedures, and interviews with the PREA Coordinator, I conclude that the agency complies with all aspects of the 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*)

The PREA Policy and Procedures states that the agency will securely retain incident-based and aggregate data and make the data collected available to the public through its website. The policy states that all personal identifiers be removed from the aggregate data that is provided to the public and that this data be maintain for at least 10 years from the date of initial collection. I reviewed the annual report for 2017 on the LSS website.

Based upon my review of the Policy and Procedures and the agency website, I conclude that the agency complies with all aspects of the standards.

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 three-year period starting on August 20, 2013, and during each three-year period thereafter, 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.? (N/A before August 20, 2016.) ☐ Yes ☒ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, 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? ☐ Yes ☒ No

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 inmates, residents, and detainees? ☒ 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*)

The agency did not begin PREA audits of their five halfway houses until 2016. However, in 2016, they began audits at all five of its facilities. I completed all five of those audits. In 2017, I completed audits of 2 LSS facilities and in 2018, I have completed audits of two facilities, Wazee House and Affinity House. LSS recently opened a new halfway house in Barronette, WI. With a total of 6 halfway houses, the agency will be required to audit 2 facilities per year. According to the PREA Coordinator, the agency will continue to schedule two audits per year to comply with the standards.

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, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. 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*)

As mentioned above, I have completed audits of all 6 LSS halfway houses since 2016. Including this report, I have audited 3 of those facilities two times. A total of 9 audits have been completed to date. I reviewed the LSS website and seven audit reports are published on the website. The recently completed Wazee and Affinity reports haven't yet been published.

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:

Lawrence J. Mahoney December 10, 2018

Auditor Signature **Date**