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

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: ☒ **N/A**
If no Interim Audit Report, select N/A
Date of Final Audit Report: 2/24/2022

Auditor Information

Name: Dave Andraska	**Email:** ddafalls@hotmail.com
Company Name: Andraska Consulting, LLC	
Mailing Address: PO Box 191	**City, State, Zip:** Melrose, WI
Telephone: 715 896-2648	**Date of Facility Visit:** January 20-21,2022

Agency Information

Name of Agency: Lutheran Social Services of Wisconsin & Upper Michigan, Inc. (LSS)			
Governing Authority or Parent Agency *(If Applicable)*:			
Physical Address: 6737 W. Washington Street Suite 2275		**City, State, Zip:** West Allis, WI 53214	
Mailing Address:		**City, State, Zip:**	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: www.lsswis.org			

Agency Chief Executive Officer

Name: Hector Colon	
Email: hector.colon@lsswis.org	**Telephone:** 414-246-2702

Agency-Wide PREA Coordinator

Name: Laurie Lessard	
Email: laurie.lessard@lsswis.org	**Telephone:** 715 465-5735
PREA Coordinator Reports to: Tara Treglowne, Vice President	**Number of Compliance Managers who report to the PREA Coordinator:** 0

Facility Information

Name of Facility: Barron Area Residential Treatment Facility (BART)			
Physical Address: 806 29 ½ Avenue		**City, State, Zip:** Barronett, WI 54813	
Mailing Address (if different from above):		**City, State, Zip:**	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: www.lsswis.org

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

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

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe:

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
Wisconsin DHS internal audit in 2019, CPC audit 3/12/2019

Facility Director

Name:	Shelley Hammes		
Email:	shelley.hammes@lsswis.org	**Telephone:**	715 214-3404

Facility PREA Compliance Manager

Name:	Laurie Lessard		
Email:	laurie.lessard@lsswis.org	**Telephone:**	715 465-5735

Facility Health Service Administrator ☒ N/A

Name:			
Email:		**Telephone:**	

Facility Characteristics

Designated Facility Capacity:	8
Current Population of Facility:	5

Average daily population for the past 12 months:	4.5
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males
Age range of population:	18-64
Average length of stay or time under supervision	70 days
Facility security levels/resident custody levels	Community

Number of residents admitted to facility during the past 12 months	35
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	35
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	25
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☒ Yes ☐ No

Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☒ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: ☐ N/A

Number of staff currently employed by the facility who may have contact with residents:	6
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
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

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

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☐ Yes ☒ No

Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations

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

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

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 1
List of Standards Exceeded: 115.211

Standards Met

Number of Standards Met: 40

Standards Not Met

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

Post-Audit Reporting Information

General Audit Information	
Onsite Audit Dates	
1. Start date of the onsite portion of the audit:	1/20/2022
2. End date of the onsite portion of the audit:	1/21/2022
Outreach	
3. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	☒ Yes ☐ No
a. If yes, identify the community-based organizations or victim advocates with whom you corresponded:	JDI – no response, contacted multiple times-mail box full, Barron County Victim Services, Community Referral Agency,
Audited Facility Information	
4. Designated Facility Capacity:	8
5. Average daily population for the past 12 months:	4.5
6. Number of inmate/resident/detainee housing units: DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house inmates of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.	0
7. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	☐ Yes ☐ No

	☒ N/A for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)
Audited Facility Population on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees	
8. Enter the total number of inmates/residents/detainees housed at the facility as of the first day of the onsite portion of the audit:	5
9. Enter the total number of youthful inmates or youthful/juvenile detainees housed at the facility on the first day of the onsite portion of the audit:	0
10. Enter the total number of inmates/residents/detainees with a physical disability housed at the facility as of the first day of the onsite portion of the audit:	0
11. Enter the total number of inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) housed at the facility as of the first day of the onsite portion of the audit:	0
12. Enter the total number of inmates/residents/detainees who are Blind or have low vision (visually impaired) housed at the facility on the first day of the onsite portion of the audit:	0
13. Enter the total number of inmates/residents/detainees who are Deaf or hard-of-hearing housed at the facility on the first day of the onsite portion of the audit:	0
14. Enter the total number of inmates/residents/detainees who are Limited English Proficient (LEP) housed at the facility as of the first day of the onsite portion of the audit:	0
15. Enter the total number of inmates/residents/detainees who identify as lesbian, gay, or bisexual housed at the facility as of the first day of the onsite portion of the audit:	0
16. Enter the total number of inmates/residents/detainees who identify as transgender, or intersex housed at the facility as of the first day of the onsite portion of the audit:	0
17. Enter the total number of inmates/residents/detainees who reported sexual abuse in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
18. Enter the total number of inmates/residents/detainees who reported sexual harassment in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
19. Enter the total number of inmates/residents/detainees who disclosed prior sexual victimization during risk screening housed at the facility as of the first day of the onsite portion of the audit:	0
20. Enter the total number of inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization housed at the facility as of the first day of the onsite portion of the audit:	0
21. Enter the total number of inmates/residents/detainees who are or were ever placed in segregated housing/isolation for having reported sexual abuse in this facility as of the first day of the onsite portion of the audit:	0

22. Enter the total number of inmates/residents detained solely for civil immigration purposes housed at the facility as of the first day of the onsite portion of the audit:	0
23. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	
Staff, Volunteers, and Contractors *Include all full- and part-time staff employed by the facility, regardless of their level of contact with inmates/residents/detainees*	
24. Enter the total number of STAFF, including both full- and part-time staff employed by the facility as of the first day of the onsite portion of the audit:	6
25. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
26. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
27. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit. *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	The facility had 6 full time staff employed on the first day of the onsite audit.
Interviews	
Inmate/Resident/Detainee Interviews	
Random Inmate/Resident/Detainee Interviews	
28. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	5
29. Select which characteristics you considered when you selected random inmate/resident/detainee interviewees:	☐ Age ☐ Race ☐ Ethnicity (e.g., Hispanic, Non-Hispanic) ☐ Length of time in the facility ☐ Housing assignment ☐ Gender ☒ Other (describe) Interviewed all residents at the facility. ☐ None (explain)

30. How did you ensure your sample of random inmate/resident/detainee interviewees was geographically diverse?	Interviewed all residents at the facility.
31. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	☐ Yes ☒ No
a. If no, explain why it was not possible to interview the minimum number of random inmate/resident/detainee interviews:	There were only 5 residents housed at the facility on the first day of the onsite audit.
32. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	All interviews were conducted using COVID-19 safety protocols such as social distancing and both the auditor and interviewees wearing masks.
Targeted Inmate/Resident/Detainee Interviews	
33. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	0
34. Enter the total number of interviews conducted with youthful inmates or youthful/juvenile detainees using the "Youthful Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
35. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.

36. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
37. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
38. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
39. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
40. Enter the total number of interviews conducted with inmates/residents/detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
41. Enter the total number of interviews conducted with inmates/residents/detainees who identify as transgender or intersex "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0

a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
42. Enter the total number of interviews conducted with inmates/residents/detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0

a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
43. Enter the total number of interviews conducted with inmates/residents/detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
44. Enter the total number of interviews conducted with inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Alleged to have Suffered Sexual Abuse)" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	This auditor interviewed and reviewed confidential case files for all residents at the facility and also interviewed all staff at the facility. No residents in this targeted category were discovered.
45. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	

Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
46. Enter the total number of RANDOM STAFF who were interviewed:	4
47. Select which characteristics you considered when you selected RANDOM STAFF interviewees (select all that apply):	☐ Length of tenure in the facility ☐ Shift assignment ☐ Work assignment ☐ Rank (or equivalent) ☒ Other (describe) Interviewed all staff at the facility ☐ None (explain) Click or tap here to enter text.
48. Were you able to conduct the minimum number of RANDOM STAFF interviews?	☒ Yes ☒ No
a. If no, select the reasons why you were not able to conduct the minimum number of RANDOM STAFF interviews (select all that apply):	☐ Too many staff declined to participate in interviews ☐ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☒ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other (describe)
b. Describe the steps you took to select additional RANDOM STAFF interviewees and why you were still unable to meet the minimum number of random staff interviews:	Interviewed all staff at the facility.
49. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	All interviews were conducted using COVID-19 safety protocols such as social distancing and both the auditor and interviewees wearing masks.

Specialized Staff, Volunteers, and Contractor Interviews *Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that interview would satisfy multiple specialized staff interview requirements.*	
50. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	5
51. Were you able to interview the Agency Head?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the Agency Head:	
52. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the Warden/Facility Director/Superintendent or their	

designee:	
53. Were you able to interview the PREA Coordinator?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the PREA Coordinator:	
54. Were you able to interview the PREA Compliance Manager?	☐ Yes ☐ No ☒ N/A (N/A if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)
a. If no, explain why it was not possible to interview the PREA Compliance Manager:	

. Select which SPECIALIZED STAFF roles were interviewed as part of this audit (select all that apply):	☐ Agency contract administrator ☐ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☐ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☒ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☒ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☒ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☒ Staff on the sexual abuse incident review team ☒ Designated staff member charged with monitoring retaliation ☒ First responders, both security and non-security staff ☒ Intake staff ☐ Other (describe) Click or tap here to enter text.
56. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?	☐ Yes ☒ No
a. Enter the total number of VOLUNTEERS who were interviewed:	0

b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit (select all that apply):	☐ Education/programming ☐ Medical/dental ☐ Mental health/counseling ☐ Religious ☐ Other
57. Did you interview CONTRACTORS who may have contact with inmates/residents/detainees in this facility?	☐ Yes ☒ No
a. Enter the total number of CONTRACTORS who were interviewed:	0

b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit (select all that apply):	☐ Security/detention ☐ Education/programming ☐ Medical/dental ☐ Food service ☐ Maintenance/construction ☐ Other
58. Provide any additional comments regarding selecting or interviewing specialized staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	The facility does not have volunteers or contractors.

Site Review and Documentation Sampling

Site Review

PREA Standard 115.401(h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: discussions related to testing critical functions are expected to be included in the relevant Standard-specific overall determination narratives.

59. Did you have access to all areas of the facility?	☒ Yes ☐ No
a. If no, explain what areas of the facility you were unable to access and why.	
Was the site review an active, inquiring process that included the following:	
60. Reviewing/examining all areas of the facility in accordance with the site review component of the audit instrument?	☒ Yes ☐ No
a. If no, explain why the site review did not include reviewing/examining all areas of the facility.	
61. Testing and/or observing all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., intake process, risk screening process, PREA education)?	☒ Yes ☐ No

a. If no, explain why the site review did not include testing and/or observing all critical functions in the facility.	
62. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	☒ Yes ☐ No
63. Informal conversations with staff during the site review (encouraged, not required)?	☒ Yes ☐ No
64. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	During the site review, this auditor verified the cross-gender announcements were made by staff when entering Resident rooms. This auditor verified that notice of audit was posted, PREA information and signage was posted and inspected all areas for blind spots and cross-gender viewing capabilities.
Documentation Sampling	
Where there is a collection of records to review—such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files—auditors must self-select for review a representative sample of each type of record.	
65. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	☒ Yes ☐ No
66. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	During the on-site review this auditor reviewed employee files for PREA questions, criminal history checks, and reference checks. The auditor reviewed six employee training files for initial and annual PREA training. This auditor reviewed one investigative file, and 14 resident files for initial intake screenings, 30-day reassessments, initial PREA information at intake, and comprehensive PREA education.
Sexual Abuse and Sexual Harassment Allegations and Investigations in this Facility	
Sexual Abuse and Sexual Harassment Allegations and Investigations Overview	
Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. *Note: For question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.*	

67. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	1	1	1	1
Total	1	1	1	1

a. If you were unable to provide any of the information above, explain why this information could not be provided.	

68. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for "convicted.") Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

69. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	**0**	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.

70. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	1
Total	0	0	0	1

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

71. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	

72. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

73. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:	1
a. If 0, explain why you were unable to review any sexual abuse investigation files:	
74. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	☒ Yes ☐ No ☐ N/A (N/A if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
75. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
76. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any inmate-on-inmate sexual abuse investigation files)
77. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
78. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
79. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	☒ Yes ☐ No ☐ N/A (N/A if you were unable to review any staff-on-inmate sexual abuse investigation files)
80. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	☒ Yes ☐ No

	☐ N/A (N/A if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
81. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. If 0, explain why you were unable to review any sexual harassment investigation files:	There were no sexual harassment allegations/investigations
82. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any sexual harassment investigation files)

Inmate-on-inmate sexual harassment investigation files	
83. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
84. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any inmate-on-inmate sexual harassment investigation files)
85. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
86. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
87. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-inmate sexual harassment investigation files)
88. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-inmate sexual harassment investigation files)
89. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files. *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	
Support Staff Information	
DOJ-certified PREA Auditors Support Staff	
90. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? *Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final*	☐ Yes ☒ No

report. Make sure you respond accordingly.	
a. If yes, enter the TOTAL NUMBER OF DOJ-CERTIFIED PREA AUDITORS who provided assistance at any point during the audit:	
Non-certified Support Staff	
91. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? *Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.*	☐ Yes ☒ No
a. If yes, enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT STAFF who provided assistance at any point during the audit:	
Auditing Arrangements and Compensation	
92. Who paid you to conduct this audit?	☒ The audited facility or its parent agency ☐ My state/territory or county government (if you audit as part of a consortium or circular auditing arrangement, select this option) ☐ A third-party auditing entity (e.g., accreditation body, consulting firm) ☐ Other

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*)

The following evidence was analyzed in making the compliance determination:
1. Documents: (*Policies, directives, forms, files, records, etc.*)
   a. BART Pre-Audit Questionnaire (PAQ) responses
   b. LSS ARJ PREA Policy and Procedure (revised 4/2021)
   c. PREA Notice to Residents
   d. LSS Organizational Chart
2. Interviews:
   a. PREA Coordinator
   b. Random staff
   c. Random residents
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:

115.211(a):

During the pre-onsite portion of this audit, the Facility provided the LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. This is a written policy that mandates zero tolerance toward all forms of sexual activity, including sexual abuse and sexual harassment, and to provide guidelines to address the following prohibited and/or illegal sexually abusive behavior. The LSS ARJ PREA Policy includes several major elements and guidelines to:

- Help detect incidents, perpetrators, and resident victims of sexually abusive behavior
- Help prevent sexually abusive behavior
- Educate staff to intervene properly and in a timely manner
- Document, report, and investigate reported incidents
- Discipline and/or prosecute perpetrators

The policy further states, “The protection and safety of staff and residents who are sexually victimized is a top priority and is addressed throughout this policy.” Additionally, the policy includes PREA definitions and prohibited behaviors, to include: non-consensual sexual act, staff sexual misconduct, staff sexual harassment of a resident, resident-on-resident abusive sexual contact, resident-on-resident sexual assault, and resident sexual harassment. Retaliation for reporting sexual abuse, harassment, or misconduct is prohibited. Upon arrival at the facility all residents receive the PREA Notice to Residents. The PREA Notice to Residents also describes the agency zero tolerance policy and the agency’s effort to implement PREA standards.

During the on-site visit, I observed the Notice of Audit and PREA information for residents posted in the facility. Based upon my review of all current resident files and interviews, I confirmed that residents receive PREA information at intake and had a good understanding of various reporting options. Based upon interviews with all staff and file reviews, I confirmed that staff receive PREA training upon hire and update training on a regular basis. All staff stated that PREA issues are frequently discussed at staff meeting and in discussions with supervisors. Staff were well versed on their responsibilities per the PREA policy and training.

115.211(b):

During the pre-onsite portion of this audit, the Facility acknowledged compliance with this provision in its PAQ response. The facility reported the Director of Residential Programming for LSS is the PREA Coordinator and provided the auditor with an organizational chart of the agency. The agency’s organizational chart reveals that the PREA Coordinator reports directly to the Vice President of Residential Programming who reports to the Chief Operating Officer. During the onsite portion of this audit, the auditor interviewed the PREA Coordinator. She is very knowledgeable of PREA standards and has the authority to develop, implement, and oversee PREA compliance. In response to whether she felt that they had enough time to manage all PREA-related responsibilities, the PREA Coordinator responded: “I do, I can move other duties around and make PREA my priority.” The PREA Coordinator reported that she would identify what is causing the non-compliance and develop a corrective action designed to rectify it. She further elaborated that if it was a resource issue, she would explain the issue and need to her supervisor. Protocol would be assessed to ensure it is designed to be compliant or in need of strengthening. If a policy and procedure update is needed, all applicable personnel would receive retraining. The agency has demonstrated that it is committed to fully implementing PREA standards.

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

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

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

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.212 (b)

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

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
2. Interviews
   a. Agency Head/Chief Operating Officer Designee
3. Site Review Observations:
   a. Observations during on-site review of physical plant

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

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

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

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

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

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

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. Staffing Plan
2. Interviews
   a. Facility Director/Program Supervisor
   b. PREA Coordinator
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.213(a):
During the pre-onsite portion of this audit, the Facility indicated compliance in this provision in its PAQ responses. The Facility provided this auditor with a current staffing plan. The Facility further provided the average daily population of 4.6 residents for the past 12 months. During the on-site portion of this audit, this auditor interviewed the agency PREA Coordinator and the Facility Director. The Facility

Director indicated that the facility has a staff plan. Given the size of BART, the staffing pattern is simple. There is always a minimum of one staff member in the facility 24/7. As a licensed CBRF, BART is required to maintain staff 24/7. The staff that do the primary supervision of residents are Support Professionals. There is usually one Support Professional on each shift. During the day, the program supervisor and case manager are usually present. 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. The Facility Director reported that the Director of Residential Programming (also PREA Coordinator) conducts an annual assessment of agency wide staffing patterns. The Facility Director indicated that video monitoring is part of the plan. There are four cameras in the facility that monitor the activities of the residents and the security of the building. There is one camera outside of the staff office, primarily to monitor medication disbursement. There are also three exterior cameras. Per policy, facilities with video surveillance capability have cameras positioned per DHS 83 CBRF licensing requirements which required that client cannot be videotaped in certain living areas. Subsequently cameras may be positioned on various entry/exit doors, overhead at medication monitoring station, and between men's and women's housing units at co-ed facilities.

When asked if the staffing plan is documented, the Facility Director responded yes and informed this auditor that the Director of Residential Programming reviews and approves all Staffing Patterns on an annual basis. On a daily basis, the Facility Director is responsible for ensuring staff arrive and work shifts as assigned.

Also, while onsite, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that when assessing adequate staffing levels and the need for video monitoring, the facility considers: 1) the physical layout of each facility, 2) the composition of the resident population, 3) the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and 4) other relevant factors.

115.213(b):
During the pre-onsite portion of this audit, the Facility indicated that this provision was not applicable. Upon follow-up by this auditor, the facility indicated compliance and reported that there had been no deviations from the plan. According to interviews with the Facility Director and PREA Coordinator, BART always complies with the staffing pattern. Because of their CBRF status, they must maintain the minimum staffing pattern at all times. It was further explained that BART has in place an on-call rotation in the event the program cannot find a replacement as a result of sick or vacation coverage. If a replacement Support Professionals cannot be found the Supervisor or case manager would fill in.

115.213(c):
During the pre-onsite portion of this audit, the Facility indicated compliance within this provision in its PAQ responses. During the on-site portion of this audit, this auditor interviewed the agency PREA Coordinator. The PREA Coordinator indicated she is responsible conducting the annual review of the staffing plan. The facility has established a procedure for a review that assesses, determines, and documents whether adjustments are needed to prevailing staffing patterns, to the facility's deployment of video monitoring systems, and whether additional resources are needed to ensure adequate staffing levels. As mentioned above, the facility is very small with four client bedrooms and common living areas. From the staff office, one is able to hear most of the activities throughout the building and visually see much of the general areas. There is a large open staircase that goes from the lower level to the upper level, which allows staff to monitor movement within the facility.

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

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

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

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

115.215 (c)

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

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

115.215 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility have procedures that enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Random Staff
   b. Random Residents
   c. PREA Coordinator
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.215(a):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision in its PAQ responses and reported the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. The Facility provided this auditor the LSS ARJ PREA Policy and Procedure which states, "Pat down searches are not allowed to be performed by LSS staff at Affinity House, Cephas House, Exodus House, BART or Wazee House. The facility indicated that over the past 12 months, there have not been any cross-gender strips or cross-gender visual body cavity searches of residents. During the on-site portion of this audit, this auditor was informed that there was no cross-

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

115.215(b-c):
During the pre-onsite portion of this audit, the Facility indicated this provision was not applicable to them as it does not house females in its PAQ responses. The auditor confirmed that the facility only houses male residents per review of resident rosters. The facility reported no cross-gender strip, visual body cavity, or pat-down searches being conducted over the past 12 months. The LSS ARJ PREA Policy and Procedure clarifies the prohibition on cross-gender pat searches, and the requirement to document cross-gender pat searches.

115.215(d):
During the pre-onsite portion of this audit, the Facility provided this auditor with the LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. The policy states, "All residents can expect to have privacy while toileting, showering, and changing clothes. An important part of a safe and humane environment is freedom from sexual misconduct by staff and sexual abuse and harassment from other residents. Staff of the opposite gender, or any other cross-gender staff, may view breasts, buttocks, or genitalia only in an exigent circumstances, or when incidental to security checks of these designated areas of the facility. Staff are not required to make announcements when responding to temporary and unforeseen circumstances that require immediate action in order to combat a threat to the security or order of a facility, or when incidental to routine bed checks, to include circumstances such as responding to alarms, or detecting behavior which would constitute a prohibited act." It further states, "Residents are notified of the presence of opposite-gender staff members in several ways:
1) Residents are advised of the requirement to remain clothed, in the presence of cross-gender staff generally, during the Intake Process and the Admission and Orientation Process.
2) The following notice is posted on bulletin boards in the resident lounge areas: "NOTICE TO RESIDENTS: Male and female staff routinely work and visit resident housing areas." The exception to this is at Affinity House which employs an all-female staff.
3) When a staff member enters the housing area of cross-gender residents, staff will announce their presence in the unit upon entry of that unit. Staff will state, "Female/Male on the unit"

During the onsite portion of this audit, this auditor interviewed 5 residents and all staff. All residents interviewed reported that staff knock and announce their presence prior to opening their bedroom doors. All residents reported that they had never seen a female staff enter their bedrooms. The residents reported that the announcement is generally "female staff". This auditor also made observations and engaged informal conversations with residents and staff while conducting the facility tour. This auditor observed all female staff announcing their presence when entering a housing area and/or resident's bedroom. There are no cameras located in resident bedrooms or bathrooms.
All staff reported that female staff announces their presence when entering a resident's bedroom or when entering the bathroom. Also, all staff reported that residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender. This facility's policies and practice evidenced that staff are aware that if a female staff were to enter the housing unit, they are to announce their presence.

115.215(e-f):
The facility PREA policy prohibits staff from conducting any body searches or pat downs of residents under any circumstances, and it does not provide training in this area. During the onsite portion of this audit, this auditor conducted six facility staff interviews. All staff reported that they are prohibited from searching or physically examining any resident. When specifically asked about searching transgender or intersect residents, staff responses varied. The facility reported that there were no transgender or intersex residents residing in the program on the first day of the audit. This audit attempted to verify that by asking staff whether or not they were aware of a current resident in the facility that identified as either transgender or intersex to which this auditor was told there were not any present and that they were not aware that there were ever any transgender or intersex resident housed at the facility. Based on interviews with the PREA Coordinator and staff, no one was aware of a situation where a transgender or intersex resident was in the facility who needed to be a searched.

Corrective Action:
During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (e) of this standard as existing policy did not address this provision. The auditor and Agency agreed upon the following corrective action plan: Develop or expand existing policy to prohibit physically examining a transgender or intersex resident for the sole purpose of determining their genital status.

On February 15, 2022, the PREA Coordinator provided the auditor with a revision to section 115.215 of the LSS ARJ PREA Policy and Procedure. The following was added: A pat-down search would never be initiated on a cross-gender individual for the purposes of determining anatomical gender. At the time of referral we receive information from the referral source that identifies the anatomical/birth sex/gender for each individual.

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

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. WI DHS 83.04 code
2. Interviews
   a. Agency Head/Chief Operating Officer Designee
   b. PREA Coordinator
   c. Random Staff
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings
115.216(a-c):
During the pre-onsite portion of this audit, the Facility response on the PAQ was non-applicable for this standard. According to the PREA Coordinator, BART does not accept clients with physical disabilities. The cited several reasons for not accepting this population. Class "A" CBRF regulation prohibit the facility from accepting clients with physical disabilities. Residents must be ambulatory and must be are mentally and physically able to respond to an electronic fire alarm and exiting the facility without any help or verbal or physical prompting. Correctional clients must have sufficient cognitive ability to respond to curriculum based, CBT/MI therapy and interventions.

BART also does not accept clients who may have serious learning disabilities or very low reading levels, limited English proficiency, blind or low vision, deaf or hard of hearing. According to the PREA Coordinator, the facility does not accept these clients into the program because they would not be able to participate or benefit from in-house programs. If it is determined that a current resident has reading or comprehension limitations that were not previously known, intake staff would carefully read and explain the PREA handouts to residents. Interviews with intake staff confirmed that they access the resident's reading and comprehension level when reviewing PREA materials. They further confirmed that they never encountered a LEP resident. All of the residents interviewed stated that intake staff gave them the PREA handouts and verbally explained the material to them. According to the Agency Head, any changes to this policy of not accepting clients with disabilities, limited English proficiency, blind or low vision, and deaf or hard of hearing would require significantly more resources and would put unreasonable burdens for them financially. The contract with DOC does not require BART to accept these clients.

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

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

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

115.217 (c)

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

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal State, and local law: Make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. LSS Background Check Policy
   d. LSS Interview Guide - ARJ Residential Program
   e. Background check records
   f. Personnel files of persons hire or promoted in the past 12 months
   g. Application for Employment
2. Interviews
   a. Administrative/Human Resources Staff/ Human Capital Generalist
   b. PREA Coordinator

Findings:
115.217(a):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. This policy requires, “LSS ARJ programs prohibit 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 or sexual harassment in a correctional facility
- Has been convicted, engaging, or attempting to engage in sexual activity in the community
- Has been civilly or administratively adjudicated to have engaged in the activity described in (a) (2) of 115.217 [a.”

During the onsite portion of this audit, this auditor interviewed the Human Resources staff. This staff person reported that the Facility uses Wisconsin Department of Justice-Crime Information Bureau (CIB) and a private background check agency. LSS currently contracts with In Check to conduct criminal

background and reference checks to include institutional reference checks on all prospective employees that had prior institutional experience when necessary. In Check includes National Sex Offender Search, Wisconsin Sex Offender Registry, Wisconsin CIB, and other states where the employee has been known to reside. In Check also does the Wisconsin Caregiver Background Check thru the Department of Justice Wisconsin Online Record Check System (WORCS). A review of personnel records revealed that agency conduct necessary institutional reference checks on all prospective employees that had prior institutional experience as defined by 42 U.S.C. 1997.

115.217(b):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with the LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. This policy establishes, “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.
Per general LSS policy states, “The organization 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.” During the onsite portion of this audit, this auditor interviewed Human Resources staff. This staff person reported that the Facility considers prior incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

115.217(c):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with the LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. During the onsite portion of this audit, this auditor interviewed Human Resources staff. This staff person reported that the Agency uses Wisconsin Department of Justice-Crime Information Bureau (CIB) and a private background check agency to conduct criminal background and reference checks to include institutional reference checks on all prospective employees that had prior institutional experience when necessary.

115.217(d):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. This policy establishes, “Per general LSS policy, background checks are conducted before enlisting the services of contractors who may have contact with residents. The facility reported that in the past 12 months, there were no contracts for services where those contractors would have contact with resident. During the onsite portion of this audit, this auditor interviewed the Facility Director and she confirmed that the facility does not utilize any contractors or volunteers. Therefore there were no records available to review.

115.217(e):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. During the onsite portion of this audit, this auditor interviewed the agency Human Resources staff and she stated, LSS conducts background checks on all existing employees every four years, which complies with Wisconsin Caregiver requirements. The LSS Background Check Policy and Procedure includes language that requires the completion of Caregiver Background checks every four years, which exceeds the standard. A review of personnel files confirmed the agency conducts background checks on all existing employees every four years.

115.217(f):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with a copy of LSS Interview Guide - ARJ Residential Program and its Application for Employment. As part of the interview process, LSS specifically asks whether the applicant has ever been investigated for or convicted of any type of sexual misconduct, sexual abuse or sexual harassment in three separately delineated questions. During the onsite portion of this audit, this auditor interviewed Human Resources staff. This staff person reported that the Agency asks all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this standard. This person reported that this is done prior to hire as part of the interview process and on an ongoing basis form that is completed annually as part of their performance review. Additionally, this staff person reported that all employees have an affirmative duty to continue to disclose any such misconduct per the LSS ARJ PREA Policy and Procedure. During the onsite portion of this audit, this auditor conducted personnel file reviews selected at random which included a self-evaluation form that asked employees annually about previous misconduct (same questions that were asked during the application process).

115.217(g):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. The Policy states, “The material omissions of information pertaining to any form of sexual misconduct or the provision of materially false information at LSS ARJ programs is grounds for termination.

115.217(h):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. The Policy states, “LSS ARJ programs will provide information on substantiated allegations of sexual abuse or harassment involved a former employee upon receiving a request from an institutional employer with whom the employee has applied for work. During the onsite portion of this audit, this auditor interviewed Human Resources staff. This staff person reported that this position would be the position responsible for providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee. This staff person reported that the Agency would comply with another institution’s request for information.

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

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Agency Head
   b. Facility Director
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings
115.218(a):
During the pre-onsite portion of this audit, the Facility indicated that Agency/Facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit, completed on January 9, 2018. During the onsite portion of this audit, this auditor interviewed the Agency Head as well as the Facility Director. The Agency Head reported no new substantial expansions or modifications have been completed since the last PREA audit. LSS opened (BART) in March 2017. In making decisions for the acquisition and design of BART, safety of residents and PREA standards were considered in the design process. The Facility Director stated to this auditor that no major renovations were done to the facility nor has any changes been made to the facility's video surveillance system since the last PREA audit. All modifications were made prior to the facility to accepting residents.

115.218(b):
During the pre-onsite portion of this audit, the Facility indicated that there have been no changes or additions to their video surveillance system since the last PREA audit, completed on January 9, 2018.
During the onsite portion of this audit, this auditor interviewed the Agency Head as well as the Facility Director. They both reported no changes or additions to the video surveillance system since the facility

opened. Per policy, technology such as video surveillance will be utilized as needed and in accordance with DHS 83 licensing.

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

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

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

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. Attempt to enter into a Memorandum of Understanding
2. Interviews
   a. Random Staff
   b. PREA Coordinator
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:

115.221(a-b):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. This Policy establishes, "Law enforcement is responsible for criminal investigation of alleged assault; the Program is responsible for Administrative investigation." The policy also states, "If the sexual assault is alleged to have occurred within the last 72 hours, it is important that we do our part to preserve any possible evidence." The facility indicated in the PAQ that the agency/facility is responsible for conducting administrative sexual abuse investigations. The facility reported that the Barron County Sheriff Department is the agency that has responsibility for conducting sexual abuse investigations.

During the onsite portion of this audit, this auditor interviewed the agency investigator responsible for conducting administrative investigations of sexual abuse. She stated the agency follows a uniform evidence protocol for investigations. For administrative investigations, the LSS PREA Policy and Procedure describes steps staff should take to preserve potential evidence. LSS provided training on preserving evidence to staff using the Relias LSS Power Point training. This auditor interviewed all staff during the onsite audit. All staff were able to describe specific steps they would take following a sexual assault. There is a PREA binder in the staff office that describes the steps that staff would take following an assault. All staff reported that the agency's investigator is the PREA Coordinator; in addition, all staff indicated that if they received a report of a sexual assault they were to keep the alleged victim safe, secure the scene and protect against any destruction of evidence, call the on-call and PREA Coordinator, and immediately contact local law enforcement in order for them to begin their investigation. According to the PREA Coordinator, BART does not accept clients under the age of 18.

115.221(c):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. The PREA Policy and Procedure states that Lake View Medical Center in Rice Lake would conduct forensic exams for victims of sexual assault. All forensic medical exams will be provided free of charge to the victim. The facility will make available or provide by referral a victim advocate to accompany the victim through the forensic medical exam process.

115.221(d-e):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. The policy establishes, “Victims may request that a victim advocate accompany them through the forensic medical exam process and investigatory interviews, as well as provide emotional support, crisis intervention, information, and referrals.” LSS attempted to enter into a Memorandum of Understanding with a local rape crisis center to provide the facility with confidential emotional support services related to sexual abuse.

During the onsite portion of this audit, this auditor interviewed the agency’s PREA Coordinator. The PREA Coordinator reported, although there is not a MOU there are local agencies that will perform these service which includes the Barron County District Attorney Office, Victim /Witness services. All clients receive a list of outside support services related to sexual abuse which includes telephone numbers and mailing addresses, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. On the first day of the onsite portion of this audit, the facility indicated no residents were present in the facility that were classified as reporting a sexual abuse. The auditor attempted to corroborate this report during interviews with randomly selected residents. No residents were identified as having reporting a sexual abuse.

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

115.221(f):
During the onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with a letter to the Sheriff of Barron County requesting that they follow the requirements of paragraphs (a) through (e) of this section.

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

115.221(h):
During the pre-onsite portion of this audit, the Facility response on the PAQ was non-applicable for this provision as the agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all applicable provisions of this 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 the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure

c. Letter to the Barron County Sheriff's Department
d. Agency Website
e. Criminal and Administrative Investigative Files

2. Interviews
   a. Agency Head
   b. Investigative Staff
   c. PREA Coordinator
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:

115.222(a-c):

During the pre-onsite portion of this audit, the Facility indicated compliance with these provisions and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. The Policy establishes, "The facility will ensure that an administrative and/or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. All reported incidents will be referred to law enforcement, and all reported incidents will be investigated. This includes incidents that just happened, as well as incidents that happened months or years ago. We may work with the WI Department of Corrections or the Federal Bureau of Prisons, depending on supervision status. Specially trained individuals will be assigned to investigate promptly, thoroughly and objectively, and gather and preserve direct and circumstantial evidence." During the on-site portion of this audit, the Agency Head was interviewed and stated the agency's procedure is followed, ensuring an administrative or criminal investigation is completed for all allegations of sexual abuse or harassment. The Agency Head established that in the event of an allegation, an administrative investigation would be conducted and overseen by the PREA Coordinator and in the event of a criminal investigation, the law enforcement agency having jurisdiction is notified and requested to investigate. During both resident and staff interviews, the auditor questioned whether or not the interviewee was aware of any instances of sexual abuse or sexual harassment while they resided/worked at the facility in an attempt to verify that all instances of sexual abuse and sexual harassment were disclosed to this auditor. No disclosures were made.

During the pre-onsite portion of this audit, the Agency indicated that over the past 12 months, there had been one allegation referred for criminal investigation. The Agency provided the auditor with an investigative file that included documentation of the referral to the Barron Sheriff's Department. During the onsite portion of the audit, the auditor interviewed the Agency's PREA Coordinator who oversees all administrative investigations within the facilities. The PREA Coordinator established that all allegations of sexual abuse are referred for investigation to the Barron County Sheriff's Department, unless the allegation does not involve potentially criminal behavior.

115.222(d-e): The auditor is not required to audit these provisions.

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

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

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

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. Training records
   d. PREA Training curriculum
   e. Weekly staff meeting minutes
2. Interviews
   a. Random Staff
   b. PREA Coordinator
   c. Facility Director/Program Supervisor

Findings:
115.231(a-b):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "All staff and volunteers will receive training at hire and at regular intervals throughout the year in order to understand and acknowledge compliance with LSS' zero tolerance policy toward sexual abuse,

misconduct or harassment at any LSS Addiction and Restorative Justice (ARJ) Program. This includes between program staff, between residents, or between a staff person and a client. The training also includes information on how to detect signs of abuse and how to effectively communicate with LGBTQ residents.
At hire, all staff and volunteers are provided with trainings related to the zero tolerance policy and PREA. See New Hire Training Document. This issue is also covered in the LSS Employee Handbook and in the PREA Policy within the PREA Binder at each program. The topic is also covered in DHS 12 and 13, part of training provided at hire."

The facility provided this auditor with information on the PREA training power point course using Relias training that all staff are required to complete. A review of this course reveals that it covers all the criteria described in the standard. The slides include information on specific approaches for supervising male clients. During the onsite portion of this audit, this auditor interviewed six staff and conducted six training file reviews. All six staff informed this auditor that they had received training at hire and annually in each of the enumerated required trainings required under this standard. A review of six training files revealed that all six staff received the aforementioned training.

115.231(c):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in PAQ responses. The Policy establishes, "Additionally, at least quarterly the Program Supervisor will provide refresher training on any portion of policy and procedures related to PREA during regularly scheduled in-service. In-service is part of the weekly Staff Meeting at all residential facilities."

The PAQ indicated all six staff were trained or retrained on the PREA requirements. During the onsite portion of this audit, the auditor reviewed training files. The files evidenced completion of annual refresher PREA trainings for all staff. In addition this auditor reviewed the weekly staff meeting minutes which indicated quarterly the Program Supervisor provided In-service refresher training. Interviewers with random staff indicated PREA was discussed during the weekly meetings.

115.231(d):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The aforementioned training records are documented in two ways: 1) the annual policy review and acknowledgement is documented by employee signature; 2) the completion of trainings is documented through a password protected that is unique for each employee. Management can then go into Relias Learning as an administrator and audit/review the status of completed trainings and print a master list of completed trainings per employee.

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

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Facility Director/Program Supervisor
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.232(a):
During the pre-onsite portion of this audit, the Facility indicated this standard was non-applicable in the PAQ responses. The LSS PREA Policy and Procedures states that volunteers (or interns) and contractors are required to complete the PREA training in Relias. The PAQ response indicates zero as the number of volunteers and contractors who have contact with residents have been trained. The Facility Director reports that BART currently has no contractors, volunteers, or interns. The auditor confirmed the facility does not utilize the services of contractors or volunteers.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all provisions of this 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
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. Pre-Audit Questionnaire (PAQ) responses
   b. LSS ARJ PREA Policy and Procedure
   c. Resident Handbook
   d. Resident Confidential Case Files
   e. PREA Notice to Residents
2. Interviews:
   a. Intake Staff
   b. Random Residents
3. Site Review Observations:
   a. Observations during on-site review of physical plant
   b. PREA education materials/posted PREA Notices to Residents

Findings
115.233(a):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. This Policy establishes, “During the intake process, residents receive information explaining the agency’s zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of abuse or sexual harassment. 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. The information is read to residents and extra effort given to residents who have limited reading levels. The Resident Handbook contains identical PREA information. We do not accept residents who are limited English proficient, deaf, visually impaired or who have physical disabilities.” The facility indicated that over the past 12 months 32 residents were admitted and given this information at intake.

During the onsite portion of the audit, the auditor interviewed the interviewed intake staff. Intake Staff in this facility include Facility Director and Case Manager. Upon intake, the resident is provided and reviews with staff the PREA Notice to Residents. All current residents were formally interviewed during the onsite portion of this audit. During the interviews, residents were asked specifically if they received information or 1) your right to not be sexually abused or sexually harassed, 2) how to report sexual

abuse or sexual harassment, 3) your right not to be punished for reporting sexual abuse or sexual harassment, and 4) whether the resident received information about the facility's rules against sexual abuse and harassment. Every resident answered that they received all of the above-listed information and that staff did so within hours of them arriving to the facility.
A random sample of 14 resident files were selected of active and past residents by this auditor to review to ensure documentation of the resident's participation in the above-listed informational sessions. All resident files included a signed copy of "Prison Rape Elimination Act (PREA) Notice to Residents-Receipt and Acknowledgement form. This document was used by the auditor to verify participation in the education session.

115.233(b):
During the onsite portion of the audit, as indicated above in provision (a), all resident interviews conducted onsite and review of case files of all residents currently in the facility indicated that all residents receive education pertinent to this provision upon admission to the facility.

115.233(c):
As indicated in section 115.216, BART also does not accept clients who may have serious learning disabilities or very low reading levels, limited English proficiency, blind or low vision, deaf or hard of hearing. According to the PREA Coordinator, the facility does not accept these clients into the program because they would not be able to participate or benefit from in-house programs. If it is determined that a current resident has reading or comprehension limitations that were not previously known, intake staff would carefully read and explain the PREA handouts to residents. Interviews with intake staff confirmed that they access the resident's reading and comprehension level when reviewing PREA materials.

115.233(d):
A random sample of 14 resident files was selected by the auditor to review to ensure documentation of the resident's participation in the above-listed informational sessions. All resident files included documentation of a signed copy of the Prison Rape Elimination Act (PREA) Notice to Residents-Receipt and Acknowledgement form. As reviewed in provision (a) of this standard, this acknowledgement covers information pertaining to the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

115.233(e):
During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided a copy of the Prison Rape Elimination Act (PREA) Notice to Residents. During the onsite portion of this audit, this auditor observed the above-referenced PREA Notices posted throughout the facility. Additionally, while onsite the auditor requested and was provided with a copy of the Resident Handbook. The handbook contains the same information as the (PREA) Notice to Residents.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all provisions of this 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 receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. NIC Completion of Training Certificates
2. Interviews:
   a. Investigative Staff
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.234(a):
During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided this auditor with training certificate for three staff, indicating completion of a training titled "PREA- Investigating Sexual Abuse in a Confinement Setting." During the onsite portion of the audit, this auditor interviewed an agency investigator. This person indicated they have received the NIC training titled "PREA- Investigating Sexual Abuse in a Confinement Setting" in addition to the general PREA training provided to all employees

115.234(b):
During the pre-onsite portion of this audit, the Facility indicated compliance in this standard and provided this auditor with training certificates for three agency staff completing the investigator training. During the onsite portion of this audit, this auditor interviewed an agency investigator. This staff person reported that the training covered 1) techniques for interviewing sexual abuse victims; 2) proper use of Miranda and Garrity warnings; 3) Sexual abuse evidence collection in confinement settings; and 4) criteria and evidence required to substantiate a case for administrative action or prosecution referral. This auditor was able to corroborate completion of this training by reviewing the identified person's training records.

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

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

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

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

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

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

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

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

115.235 (b)

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

115.235 (c)

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

115.235 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents: (Policies, directives, forms, files, records, etc.)
   a. BART PAQ responses
   b. Staff List
2. Interviews
   a. PREA Coordinator
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings
115.235(a-c):
During the pre-onsite portion of this audit, the Facility indicated that BART does not employ medical or mental health staff. During the onsite portion of this audit, this auditor attempted to corroborate the Facility's PAQ response by reviewing a staff list of program personnel and by interviewing the PREA Coordinator. The PREA Coordinator confirmed that BART does not employ any medical or mental health staff and that residents obtain these services through community-based organizations. A review of the staff list provided revealed no medical or mental health staff listed.

115.235(d):
During the pre-onsite portion of this audit, the Facility indicated that BART does not employ medical or mental health staff nor does LSS have any practitioners contracted with and volunteering at BART.
During the onsite portion of this audit, this auditor attempted to corroborate the Facility's PAQ response by reviewing a list of contractors and volunteers and by interviewing the PREA Coordinator. The PREA Coordinator confirmed that LSS does not have any medical or mental health practitioners under contract or volunteering at the facility. A review indicated BART does not have any contractors and/or volunteers.

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

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*)

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. LSS ARJ Sexual Vulnerability/Predation Risk Assessment form
   d. Resident confidential case files
2. Interviews
   a. Random Residents
   b. Staff responsible for risk screening
   c. Random Staff
   d. PREA Coordinator/Director of Operations
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Finding):
115.241(a) and (b):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. The Policy establishes, "During orientation, residents be screened for risk within 72 hours of intake …" The facility indicated that over the past 12 months 32 residents were admitted and assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents. During the onsite portion of this audit, this auditor reviewed 14 random resident confidential case files. All files indicated that the resident completed "LSS ARJ Sexual Vulnerability/Predation Risk Assessment" on the date of admission to the facility. Every risk screening was evidenced to be conducted on the resident's admission date. All residents reported that staff conducted this questionnaire within hours of their arrival to the facility. This auditor also interviewed staff responsible for risk screening. At BART, Case Managers are responsible for conducting the risk screening and stated risk screening is conducted within hours of a resident's arrival.

115.241(c):
During the onsite portion of this audit, the Facility indicated compliance in this standard and provided this auditor with a copy of their risk-screening form: "LSS ARJ Sexual Vulnerability/Predation Risk Assessment form." A review of this form indicates that it requires screening staff to assess the screened resident using eight "vulnerability factors" and six "aggressive/predatory factors" through a series of yes and no questions. Screening staff are then required to review the answers provided and total the yes responses. As a result, the facility's screening instrument is objective as the results are measurable and the same results could be reproduced by other staff.

115.241(d-e):

A review of the facility's risk screening tool, titled: "LSS ARJ Sexual Vulnerability/Predation Risk Assessment" establishes that it assesses and includes all the criteria required by these provisions to determine the resident's risk of victimization or abusiveness.

115.241(f):
During the pre-onsite portion of this audit, the Facility provided P LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. The Policy establishes "that a reassessment shall be done not to exceed 30 days after arrival. The facility indicated that over the past 12 months 100% of the residents that were admitted to the facility whose length of stay in the facility was for 30 days or more were reassessed for their risk of sexual victimization or of being sexually abusive within 30 days after arrival. During the onsite portion of the audit, this auditor conducted 14 random resident confidential file reviews, 12 of which were for residents currently in the facility longer than 30 days. 12 files contained re-assessments within 30 days after a resident's arrival at the facility. This auditor interviewed all five current residents; three residents reported to this auditor that they were asked risk screening questions after their initial intake with their case manager/screening staff. The other two residents recently arrived at the facility and were not there for 30 days. This auditor also interviewed two case managers – the staff designated as being responsible for conducting the re-assessment at the facility. All case managers indicated that they conduct a re-assessment within 30 days of the resident's admission.

115.241(g):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "A reassessment will be conducted when warranted due to a referral, request, incident of sexual abuse or additional information is received that bears on the resident's risk of sexual victimization." During the onsite portion of the audit, this auditor interviewed two case managers and they indicated that they would conduct a re-assessment in the event that there was a new report or incident of sexual abuse, information unknown at the time of intake from the referral source, a request, or if they were in receipt of any additional information that bears on a resident's risk of sexual victimization or abusiveness.

115.241(h):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "No sanctions will be applied who refuse to answer or respond to the certain questions during the screen."
During the onsite portion of the audit, this auditor interviewed two case managers and they indicated residents would not be discipline for refusing to answered questions during screening. They further stated they do not recall a time when a resident refused to comply.

115.241(i):
During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that the Agency has implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. Only Case Managers have access to the risk assessment forms. Completed risk assessments are stored in the Program Supervisor office in a locked cabinet.

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

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses

b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Random Residents
   b. PREA Coordinator
   c. Staff responsible for risk screening
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.242(a):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance with this standard in its PAQ responses. The Policy indicates room assignments and general program participation will be predicated on the findings of the assessment.
During the onsite portion of this audit, this auditor interviewed the PREA Coordinator and staff responsible for risk screening. The PREA Coordinator reported that the facility utilizes the screening assessment to determine whether or not each incoming resident is scored as a low, medium or high risk of being victimized or abusive. Assessments with a medium or high score will be reviewed each week with the clinical team during Clinical Supervision meetings, at which time appropriate recommendations will be determined. Staff responsible for risk screening reported that the risk assessment is utilized to inform the staff what room and bed assignment the resident can reside in. The staff reported that they would never place a known or potential victim with a known or potential abuser. The staff revealed that the residents are placed in a room/bed assignment consistent with their risk-level. Due to the small size of the facility, all residents attend the same programming in the morning and are under direct supervision of a case manager.

115.242(b):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. During the assessment process, staff ask all residents, including LGBTI residents, how they feel about their own safety. Assessments with a medium or high score will be reviewed each week with the clinical team during Clinical Supervision meetings, at which time appropriate recommendations will be determined. During the onsite portion of this audit, this auditor interviewed staff responsible for risk screening. Staff responsible for risk screening reported that upon intake, the screening staff and/or a clinical team makes an individualized determination based on the resident's risk level about how to ensure the safety of each resident.

115.242(c):
During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that prior to entry, the Program Director or designee would consult with the referring institution or agency. Care and consideration would be given to the client's needs and when possible and where safety issues do not exist, they are housed where they feel comfortable with the referral agency's consent. Additionally, the PREA Coordinator reported that the agency considers whether the placement will ensure the resident's health and safety and whether the placement would present management or security problems.

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

115.242(d):

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that transgender and intersex resident's own views with respect to his or her own safety are given serious consideration in placement and programming assignments. Additionally, this auditor interviewed staff responsible for risk screening. This staff person reported that a resident's own views with respect to his or her own safety would be given serious consideration. This staff person could not recall a transgender or intersex resident residing at this facility while this person had been an employee. As noted in provision (c), no transgender or intersex residents were interviewed.

115.242(e):
During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that transgender and intersex residents would be able given the opportunity to shower separately from other residents, as all residents are able to shower separately from others residents. There are two individual bathrooms in the facility in which residents are able to use alone.
As noted in provision (c), no transgender or intersex residents were interviewed.

115.242(f):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, Room assignments are decided by the clinical staff and LGBTQI residents will never be assigned to a room based solely on their identification as LGBTQI. Additionally, information from the risk screening tool will be included in room assignment decisions for all residents." During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that LGBTI residents are not placed in dedicated facilities, units, or wings solely on the basis of such identification or status. The PREA Coordinator further reported that Managers responsible for housing assignments understand the significance of not discriminating against residents based on their sexual preference. During the onsite portion of this audit, the facility indicated there were no LGB residents at the facility. Therefore there were no LGB residents to interview. This auditor attempted to corroborate that through resident confidential file reviews and through random staff interviews. No residents were identified that met these criteria.

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

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

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

115.251 (c)

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. PREA Notice to Residents
   d. MOU with Rock Valley Community Programs, Inc. (RVCP)
   e. PREA Training Curriculum
2. Interviews
   a. Random Residents
   b. Random Staff
   c. PREA Coordinator

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

Findings:
115.251(a):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure and the PREA Notice to Residents in support of their compliance in this standard in its PAQ responses. The Policy states, “All residents are able to make a report if they are a victim of sexual abuse, assault, sexual misconduct, sexual harassment or staff sexual misconduct while residing in our facility.
Reports may be made in one of the following ways:

- Verbally
- In writing
- Anonymously
- By a Third Party”

The facility also provided this auditor with a PREA Notice to Residents (evidenced to be displayed throughout the facility during the site review) that indicates any resident can “report sexual abuse, sexual harassment, or staff sexual misconduct in one of the following ways: verbally, in writing, anonymously, and by a third party.”

During the onsite portion of this audit, this auditor interviewed six staff and five residents. All staff indicated that residents can report these incidents to any staff member or their case manager. They also reported that residents can report in writing, verbally in person, or through a third party. When asked when staff were trained in this, staff consistently reported during orientation, annually and at staff meetings. All resident answers varied but a review of all responses indicated that the resident was able to identify at least two ways to report; the most common answers were in-person, through a third party, hotline number, or local police (or contracting authority).

115.251(b):
During the pre-onsite portion of this audit, the Facility provided the MOU with Rock Valley Community Programs, Inc. (RVCP) and the PREA Notice to Residents in support of their compliance in this standard in its PAQ response. The MOU provides 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. When RVCP receives a report they would immediately forward the resident reports of sexual abuse and sexual harassment to LSS’s PREA Coordinator. Residents are informed as this reporting option in the PREA Notice to Residents. Residents are also informed they can call law enforcement by dialing 911. Residents can remain anonymous when contacting RVCP.

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that the facility displays the PREA Notice to Residents posters. The PREA Coordinator further reported that Residents may report anonymously, through 3rd party individuals, written, in-person or telephonically and or report via unsigned written correspondence. This auditor also interviewed five residents. All five residents indicated that they could report sexual abuse or sexual harassment to someone who does not work at this facility.

115.251(c):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. The policy mandates that staff accept all reports of abuse regardless of the manner of reporting. Staff review a

copy of this policy upon hire. The Relias PREA Power Point training, required of all employees, includes information about residents reporting abuse, and lists multiple reporting options.

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

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

115.251(d):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes that reports may be made to any staff member at the program – it is part of their job to report any allegations, to ensure resident safety and to maintain confidentiality. During the onsite portion of this audit, this auditor interviewed the all staff. All staff said that they could privately make reports to their supervisors without concerns.

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

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☒ NA

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses

b. LSS ARJ PREA Policy and Procedure
c. PREA Notice to Residents
2. Interviews
a. PREA Coordinator
3. Site Review Observations:
a. Observations during on-site review of physical plant

Findings:
115.252(a-g):
During the pre-onsite portion of this audit, the Facility response on the PAQ was that the agency does not have an administrative procedure dealing with resident grievances regarding sexual abuse. The PREA Notice to Residents states, "The LSS Grievance Resolution Process shall not be used as an administrative remedy process to address sexual abuse." Review of LSS ARJ PREA Policy and Procedure revealed there is no administrative procedure for dealing with resident grievances regarding sexual abuse. During the onsite portion of this audit, this auditor interviewed the PREA Coordinator and she confirmed the Agency does not have administrative procedures to address resident grievances regarding sexual abuse.

Based upon the review and analysis of all the available evidence, the auditors determined that the agency is compliant with all provisions of this standard.

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 following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. PREA Notice to Residents
2. Interviews
   a. Random Residents
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.253(a-c):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure and the PREA Notice to Residents in support of their compliance in this standard in its PAQ responses. The Policy establishes, "All clients will receive a list of outside support services related to sexual abuse which includes telephone numbers and mailing addresses, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. The facility will enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible. LSS will not monitor these communications, unless the resident requests that we do so, and would be done in the fashion the resident requests; ie: direct observation (in person), via telephone, or electronically via email." The PREA Notice to Residents lists a number of victim advocacy services, with addresses and phone numbers.

During the onsite portion of this audit, this auditor interviewed five residents (there were no residents designated by facility staff as having reported prior sexual abuse). Out of these resident interviews, most residents were able to inform this auditor about outside victim advocates for emotional support services related to sexual abuse.

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

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. PREA Notice to Residents
   d. Agency Website
2. Interviews:
   a. Random Staff
   b. Random Residents
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings
115.254(a):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure and the PREA Notice to Residents (evidenced to be displayed throughout the facility during the site review) in support of their compliance in this standard in its PAQ responses. The Policy establishes, "Third Party reports may be made to any of the persons identified under Resident Reporting, (of this policy) or by contacting the Lutheran Social Services main office in West Allis. Phone: 414-281-4400 Information pertaining to PREA, including third party reporting is located on the LSS website (www.lsswis.org), in the Corrections/Restorative Justice section." The PREA Notice to Residents establishes, "You can report it in one of the following ways:

- Verbally
- In writing
- Anonymously
- By a Third Party"

During the onsite portion of the audit, this auditor interviewed six staff and five residents, all were aware of third party reporting options. During the onsite portion of the audit, the facility also provided this auditor with an investigative file of an allegation of staff sexual misconduct. A review of this file revealed that the initial allegation was received by way of a third-party report. The agency provides a method to receive third-party reports and that method is publicly distributed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all provision of this 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 following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. Reports of Sexual Abuse and Sexual Harassment
2. Interviews
   a. Facility Director
   b. PREA Coordinator
   c. Random Staff
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.261(a-b):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "The facility requires all staff to report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility whether or not it is part of the agency. Further, the agency requires all staff to report immediately any incidents of retaliation against residents or staff who reported an incident. All staff are to report immediately any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in the agency policy, to make treatment, investigation, and other security and management decisions."

During the onsite portion of this audit, this auditor interviewed six facility staff. All staff interviewed reported that LSS requires all staff to report any knowledge, suspicion, or information regarding an

incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff cohesively reported that the procedure for reporting any information related to a resident sexual abuse incident would be to notify your immediate supervisor and/or the on-call, follow-up a verbal report with an Incident Report and that the report is confidential. No staff members said that they reported any information regarding sexual abuse or harassment since they began working at BART.

115.261(c):
During the pre-onsite portion of this audit, the Facility indicated that they do not have any medical or mental health practitioners on staff and those residents in need of medical and mental health services are referred to outside community-based agencies. This was verified by this auditor by review of staff rosters and human resource files.

115.261(d):
During the pre-onsite portion of this audit, the Facility indicated that they do not service anyone under the age of 18. This was verified by the auditor by reviewing the resident roster as of the first day of the audit and by interviews with the Agency Head and PREA Coordinator. As indicated in section 115.216, Correctional clients must have sufficient cognitive ability to respond to curriculum based, CBT/MI therapy and interventions. BART also does not accept clients who may have serious learning disabilities or very low reading levels, limited English proficiency, blind or low vision, deaf or hard of hearing.

115.261(e):
During the pre-onsite portion of this audit, the Facility indicated that over the past 12 months, there had been one allegation of sexual abuse. The Facility provided the auditor with the investigative file that included the outcome of the administrative investigation, the referral to and investigative efforts of the Barron County Sheriff's Office. A review of this investigative file revealed that this report was made by a third-party report from another resident. This report was made to the Facility Director. The Facility Director, in turn, immediately contacted the agency's investigator/PREA Coordinator.

During the onsite portion of this audit, this auditor interviewed the designated Facility Director. The Facility Director indicated that upon receiving any allegation, including from third-party and anonymous sources, staff are required to document the report immediately and follow PREA protocol.

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

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Agency Head
   b. Facility Director
   c. Random Staff
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.262(a):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "Staff will take steps to ensure the safety of any client believed to be in imminent danger of sexual assault. Should staff become aware of the potential of an imminent sexual assault on a client or observe a sexual assault taking place within the facility, the following steps will be taken immediately:
• Staff will call 911 and make immediate report, and will call Supervisor.
• Staff will assure that the victim or intended victim is provided with safety until the perpetrator or individual suspected of planning a sexual assault is removed. This may mean bringing the victim or intended victim to the locked staff office until the danger has been addressed."

In the past 12 months, the Facility indicated that there have no occurrences where the agency or facility determined that a resident was subject to a substantial risk of imminent sexual abuse. During the onsite portion of this audit, this auditor interviewed the Agency Head, Facility Director, and all staff. The Facility Director reported that in the event that staff learned that a resident is subject to a substantial risk of imminent sexual abuse, the facility would separate the alleged victim from the abuser and based on the specific case may remove the abuser from the facility. All Staff reported that they would take the alleged victim to the staff office and call the program Supervisor. Staff reported their primary responsibility is to make sure the resident felt safe. They reported that staff would be required to immediately notify the PREA Coordinator in order to take any steps necessary to remove the alleged aggressor. The Agency Head reported that the agency would take any steps necessary to make sure the resident was safe. After the resident was placed in a safe setting, the agency would immediately begin to investigate the claim. During the investigation, the alleged aggressor and alleged victim would be separated. Although no incidents were available to review, all staff interviewed knew to take whatever steps necessary to immediately act in the event that the facility learns that a resident is subject to a substantial risk of imminent sexual abuse.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all provision of this 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 following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Agency Head
   b. Facility Director
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.263(a-d):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes "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." The facility reported that during the past 12 months, there were no allegations the facility received that a resident was abused while confined at another facility. Therefore there was no documentation to review.

During the onsite portion of this audit, this auditor interviewed the Agency Head and the Facility Director. The Agency head reported that the designated point of contact at BART is the Facility Director who would be responsible for immediately notifying the PREA Coordinator. Upon receiving an allegation, she reported that LSS would notify the Facility Director of the facility where the alleged abuse took place and the appropriate law enforcement investigative agency, if applicable. The Facility Director reported that the agency would be responsible for immediately investigating the allegation in accordance with policy. The Facility Director reported that there are no examples of another facility or agency reporting allegations occurring while a resident was residing at Bart.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all provisions of this 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 following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Security Staff and Non-security Staff First Responders
   b. Random Staff
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.264(a-b):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, “Any staff on duty is considered a first responder in relation to reports of sexual abuse/assault. All staff will be able to take a report, respond in a situation where a sexual assault has occurred or where a client is in imminent danger, and to attend to the safety of the victim.” The Policy goes into detail of the first responder duties which includes preserving evidence. The Facility reported that during the past 12 months there were no instances where staff were notified within a time period that still allowed for the collection of physical evidence. A review of the Facility’s sexual abuse allegations over the past 12-month period, revealed that there was only one allegation made and that was an allegation made through a third-party report after the resident had discharged from the program.

During the onsite portion of this audit, this auditor interviewed all staff at the facility. There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered. In this facility, all staff disclosed they were first responders. All staff interviewed reported that as a first responder it was their responsibility to separate the alleged victim and abuser, secure the scene and call local law enforcement so they can collect any evidence that may be discoverable, not allow either the alleged

abuser or alleged victim take any actions that could destroy physical evidence, and immediately calling and an ambulance, and offering mental health services.

Based upon review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all provisions of this 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 following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Facility Director
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.265(a):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. This Policy includes specific steps that staff, investigators, and facility leadership shall take in response to an incident of sexual abuse. There are no medical or mental health staff at BART.

During the onsite portion of this audit, this auditor interviewed the Facility Director. The Facility Director indicated that the facility has a coordinate response and referenced the Policy. She then described the coordinated response plan; the expectation if staff is the first responder in the situation makes sure that the alleged victim is safe and does not take any action to destroy any physical evidence (showering,

laundering clothes, brushing teeth, smoking, etc.). Then the crime scene is preserved with staff and residents not being allowed into the area until law enforcement arrives. They then inform the Program Supervisor and the PREA Coordinator of the alleged abuse. The first responder documents all information as it was reported to them. Then the victim will be accompanied by a staff member to local medical provider for forensic exam.

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

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*)

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
2. Interviews
   a. Agency Head
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.266(a):
During the pre-onsite portion of this audit, the Facility response on the PAQ was that the agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf

has not entered into or renewed any collective bargaining agreement or other agreement since the last PREA audit. During the onsite portion of this audit, this auditor interviewed the Agency Head. The Agency head reported that no collective bargaining agreements have been entered into or renewed.

115.266(b): The auditor is not required to audit this provision.

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

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 following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure

2. Interviews
   a. Agency Head
   b. Facility Director
   c. Designated Staff Member Charged with Monitoring Retaliation
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.267(a-e):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "Retaliation is intimidation to prevent a resident (or staff person) from filing a complaint or participating in an investigation. LSS prohibits anyone from interfering with an investigation, including intimidation or retaliation against witnesses. …The Program Supervisor and Program Manager monitor staff and residents who have reported sexual abuse allegations to protect them from retaliation for 90 days. This includes daily review of staff log, daily check-in with various staff, on-going check-in with the reporting resident. However, if the initial monitoring indicates a continuing need, periodic status checks occur, and are documented.

During the onsite portion of this audit, this auditor interviewed the Agency Head, Facility Director, and the staff member charged with monitoring retaliation, The Agency Head reported that depending on the circumstances surrounding the report, they would consider changing room assignments, transfer or removal of the alleged abuser from the facility and/or to the opposite Unit, and would offer emotional support services through a local community-based agency. The Facility Director informed this auditor that if there was an immediate threat of retaliation, the accused would be removed from the facility immediately until the investigation is completed. For all other instances, action plans will be developed by the Program Manager to ensure the reporter is free from retaliation. The Facility Director reported that such measures include: housing changes or transfers, removal of abusers, make a referral for counseling or emotional support services. This auditor also interviewed a designated staff member charged with monitoring retaliation. This staff person reported that in the event there was a report, the facility would make sure the reporting party felt safe. This person would be offered emotional support services to that individual. In the event that the reporting party was a staff person, they would include the PREA Coordinator as a party to create an action plan to ensure that the staff person was free from retaliation from other staff or residents.

There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered. A review of the one allegation of sexual misconduct received by the Agency over the past 12 months revealed that the alleged victim of the allegation had already discharged from that facility prior to the report being made. As a result, there were no persons present in the facility to monitor for retaliation.

The Facility Director further reported that in the event that the facility suspected retaliation against an alleged victim or person cooperating with an investigation, she would immediately notify the PREA Coordinator. This person reported that the facility would then employ the protective measures discussed in provision (b) of this standard. The staff person interviewed that is charged with monitoring retaliation reported that she would review of staff log daily , daily check-in with various staff, and check-in with the reporting resident. The Facility reported that there have been no times an incident of retaliation occurred in the past 12 months. This auditor attempted to verify that report by reviewing the facility's allegations of sexual abuse or sexual harassment received in the past 12 months. A review of

those documents revealed that there were no instances of retaliation in the past 12 months. The facility did provide this auditor with a newly created monitoring form titled: "PREA Retaliation Monitoring Report." This form includes basic information regarding the target, the date monitoring began, the 90-day expiration, and whether the monitoring is new or an extension of a prior 90-day period. Additionally, the form requires a review of disciplinary reports, housing changes, programmatic changes, performance evaluations, staff reassignments, and face-to-face check-ins.

115.267(f): The auditor is not required to audit this provision.

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

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*)

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. Investigative records/reports for allegations of sexual abuse or sexual harassment
   d. Criminal investigation reports
   e. Administrative investigation reports
2. Interviews
   a. Investigative Staff
   b. PREA Coordinator
   c. Facility Director
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.271(a):
LSS ARJ PREA Policy and Procedure establishes the protocols for "Criminal and Administrative Agency Investigations. All reports of sexual harassment or assault of residents will be investigated by a trained team and according to relevant PREA standards. The Facility indicated that over the past 12 months, there had been one allegation of staff on resident sexual abuse resulting in an administrative investigation; this same investigation resulted in referral for criminal investigation. The Facility provided the auditor with the investigative file that included the outcome of the administrative investigation, the referral to and investigative efforts of the Barron County Sheriff's Office. This case was not referred for prosecution as the victim refused to cooperate during the Sheriff's investigation. Documentation revealed that this allegation was received by way of a third-party report and the staff person receiving the allegation reported the allegation to the agency's PREA Coordinator. The investigation resulted in

the staff person being terminated. The agency assisted the Barron County Sheriff's Department during their criminal investigation into this allegation.

The auditor was able to analyze the evidence reviewed in the administrative investigation to determine whether the agency investigated the allegation promptly, thoroughly, and objectively. Thoroughly means all potential evidence is collected and considered, including but not limited to: physical evidence, documentary evidence, video evidence, telephone records and recordings. Objectively means an investigation is conducted by an investigator without any bias or presumption. Promptly means within a reasonable amount of time to assure that evidence, including information from witnesses, victims and subjects is not lost or forgotten when allegations of sexual contact are made where a forensic medical exam is in order, the investigation starts immediately so as not to lose that evidence. The investigation into this allegation was evidenced to begin immediately after the initial report being made by the third-party reporter. The investigator was evidenced to collect all potential evidence that this person had access to, including but not limited to: cell phone pictures and texts and interviewing of potential witnesses. Lastly, the report provided indicated that the investigating staff investigated without bias or presumption and followed the evidence that was obtained; ultimately substantiating the allegation and referring the matter for a criminal investigation through the Barron County Sheriff's Department. During the on-site portion of this audit, this auditor interviewed the agency's investigator. The investigator revealed that the investigation begins immediately upon receiving the report. The investigator further stated that third-party reports are handled in the same way and are not investigated differently.

115.271(b):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided training certificates of key personnel that serve as investigators in the agency. During the onsite portion of this audit, this auditor interviewed the Agency's investigator/PREA Coordinator. The special training in sexual abuse investigations this staff person has received is indicated in Section 115.234.

115.271(c):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided the above-referenced investigative file as evidence of their compliance. During the onsite portion of this audit, this auditor interviewed the Agency's investigator. The assigned investigator would be responsible for gathering and preserving direct and circumstantial evidence, begin interviewing alleged victims, suspected perpetrators, any electronic monitoring or other electrically stored evidence, and witnesses. During the interview, the investigator indicated that on the investigation reported in the PAQ, the investigator safeguarded pictures and texts obtained on the alleged victim's cell phone, and reduced witness statements to writing.

115.271(d):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided the above-referenced investigative file as evidence of their compliance. During the onsite portion of this audit, this auditor interviewed the Agency's investigator. The investigator informed the auditor that in the event the program discovers evidence that a prosecutable crime may have taken place, the investigator would not conduct compelled interviews as these matters would be immediately referred to law enforcement who would be responsible for the criminal investigation and prosecutor consultation. In review of the investigative file provided by the Agency, the chronological log detailing investigative steps evidences that agency investigators did not conduct any compelled interviews and the matter was referred to local law enforcement.

115.271(e):

During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided the above-referenced investigative file as evidence of their compliance. During the onsite portion of this audit, this auditor interviewed the Agency's investigator. The investigator informed this auditor that the judging the credibility of an alleged victim, suspect, or witness is done in an individual basis and is assessed objectively without a presumption that one person is more credible that another until the assessment of credibility shows one way or another. The investigator further provided that under no circumstances would a resident who alleges sexual abuse be required to a polygraph examination or truth-telling device as a condition for proceeding with an investigation.

There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered. As a result, this auditor was unable to question any resident who reported prior sexual abuse in this facility to inquire whether or not the resident would be/had been required to take a polygraph test as a condition for the facility proceeding with a sexual abuse investigation.

115.271(f):
During the onsite portion of this audit, this auditor interviewed the Agency's investigator. The investigator informed this auditor that administrative investigations do include an effort to determine whether staff actions or failures to act contributed to the abuse. The investigator further established that during interviews and evidence gathering looking they actively look for the existence of staff neglect, violation of the standards of employee conduct, and whether staff maintained fidelity with the agency's policies and procedures. Additionally, the investigator reported that all administrative investigations are documented in written reports that include: a description of all physical and testimonial evidence; all questions asked of these people; a list of and responses of all witnesses, staff, or community-service providers interviews; follow-up with law enforcement as well as notification to the alleged victim; and findings along with evidence used to make the determination of substantiated, unsubstantiated, or unfounded.

115.271(g):
During the onsite portion of this audit, this auditor interviewed the Agency's investigator. The investigator informed this auditor that criminal investigations (similar to administrative investigations) are documented and retained pursuant to the Agency's record retention policy. The investigator disclosed that the local law enforcement agency provides the agency with a detailed account of all efforts completed during the investigation, including the date and time and person that completed the task. The investigator further communicated that the information includes a thorough description of any evidence obtained. A review of the investigative file provided by the facility evidencing the only referral for criminal investigation revealed that the Barron County Sheriff's Department provided routine information back to the facility as to their progress with the investigation.

115.271(h):
During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided LSS ARJ PREA Policy and Procedure as evidence of their compliance. The Policy establishes that "All reported incidents will be referred to law enforcement, and all reported incidents will be investigated." During the pre-onsite portion of this audit, the Agency indicated that over the past 12 months, there had been one allegation being referred for criminal investigation. As indicated above the case was referred to the Barron County Sheriff's Department.

115.271(i):

During the pre-onsite portion of this audit, the agency indicated compliance with this provision and provided LSS ARJ PREA Policy and Procedure as evidence of their compliance. Section II(I)(1) establishes that “Per licensing requirements, client files are retained for 7 years, and for 10 years when there is a PREA investigation.”

115.271(j):
During the onsite portion of this audit, this auditor interviewed the Agency’s investigator/PREA Coordinator. The investigator informed this auditor that the departure of the alleged abuser or victim from the employment or control of the facility or agency does not terminate the investigation pending. The investigator informed this auditor that efforts would be continued to complete the investigation.
During the pre-onsite portion of this audit, the Agency indicated that over the past 12 months, there had been one allegation resulting in an administrative investigation that was ultimately referred to the local law enforcement for criminal investigation/prosecution. This report was obtained by the facility after this particular resident had released. The investigation packet evidenced that despite the alleged victim no longer being under the control of the facility, the investigation continued.

115.271(k): Auditor is not required to audit this provision.

115.271(l):
During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator informed this auditor that LSS informs the investigating agency of the PREA standard that requires that the facility remain informed of the progress and outcome of the investigation. Additionally, facility high-level supervisory personnel revealed that in the event the LSS does not conduct the investigation, the facility requests relevant information from the investigative agency in order to jeep the resident and referral source informed.

A review of the investigative file provided by the facility evidencing the only referral for criminal investigation revealed that the Barron County Sheriff’s Department provided routine information back to the facility as to their progress with the investigation.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all applicable provisions of this 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*)

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. Investigative records/reports for allegations of sexual abuse or sexual harassment
   d. Criminal investigation reports
2. Interviews
   a. Investigative Staff

Findings:

115.272(a):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. The Policy establishes, "LSS uses a preponderance of evidence in determining whether allegations of sexual abuse or harassment are substantiated." The Facility indicated that over the past 12 months, there had been one allegation resulting in an administrative investigation; this same investigation resulted in referral for criminal investigation and prosecution. The Facility provided the auditor with the investigative file that included the outcome of the administrative investigation. During the onsite portion of this audit, this auditor interviewed the Agency's investigator. The investigator informed this auditor that the standard of evidence required to substantiate allegations of sexual abuse or sexual harassment was preponderance of evidence.

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

Standard 115.273: Reporting to residents

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

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency

in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents: (Policies, directives, forms, files, records, etc.)
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. Investigative records
   d. Criminal investigation reports
   e. Resident Notification
2. Interviews
   a. Investigative Staff
   b. Facility Director
   c. PREA Coordinator

Findings:
115.273(a):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, “After the investigation is finished, a decision will be reached and you will be informed of that decision:
1. Substantiated allegation – the allegation was investigated and determined that there was sufficient evidence to make a final determination that the event did occur. Results of the investigation will be forwarded for prosecution, i.e. District Attorney’s Office, who will determine if charges will be filed.
2. Unsubstantiated allegation – the allegation was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred.
3. Unfounded allegation – the allegation was investigated and determined not to have occurred. There is insufficient evidence to conclude the allegation is true.”

The agency indicated that over the past 12 months, there had been one allegation resulting in an administrative investigation; this same investigation resulted in referral for criminal investigation. The facility provided this auditor with a letter that was sent to the former resident that indicated that the sexual abuse allegation had been substantiated and that the alleged staff member was no longer employed at the facility and had been included as a suspect a criminal case presented to local authorities. During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator indicated that following an investigation, LSS informs the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Review of this investgative file indicated, although the resident was released from the facility, the Agency contacted the former resident to inform him of the outcome. There were no residents who reported a sexual abuse while this auditor was at the facility available to be interviewed.

115.273(c):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, “Reporting

resident will be informed as to outcome of administrative and/or criminal investigation, whether the case was found to be substantiated, unsubstantiated, or unfounded, as well as:

- Updated on any involved staff member in terms of placed on leave and/or no longer an LSS employee
- Updated on disposition of any involved resident in terms of indictments or convictions as result of the report
- Outcome of any criminal investigation or indictment/conviction of involved staff as a result of the report
- All resident notifications will be documented in the client chart."

The facility provided this auditor with a letter sent to the former resident that indicated that the sexual abuse allegation had been substantiated and that the alleged staff member was no longer employed at the facility and had been included as a suspect a criminal case presented to local authorities. As indicated in provision (a) of this standard, there were no residents who reported a sexual abuse while this auditor was at the facility available to be interviewed

115.273(d):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "LSS ARJ programs have no ability to discipline a correctional client for sexual assault/harassment. However, the relevant correctional entity will be immediately contacted should a report be made about a client and removal requested at least during the investigation." The facility reported that there were no instances of resident-on-resident abuse in the facility to review. This auditor attempted to corroborate that report during interviews with random staff and while reviewing resident confidential case files.

115.273(e):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "All resident notifications will be documented in the client chart." As reviewed in provisions (a) through (c) of this standard, the facility provided this auditor with documentation evidencing that the only notification made pursuant to this standard was documented.

115.273(f): the Auditor is not required to audit this provision.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all applicable provisions of this 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 following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. Investigative file including documentation termination and notification of law enforcement.
2. Interviews
   a. PREA Coordinator
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.276(a-c):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "Disciplinary 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. At LSS ARJ programs, staff found to have

engaged in sexual harassment, sexual misconduct, sexual abuse under PREA will be terminated from employment." During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that any staff that violated the agency sexual abuse or sexual harassment policy (as well as the Employee Standards of Conduct) would be subject to disciplinary sanctions up to

During the pre-onsite portion of this audit, the Facility indicated that there had been one staff from the facility that had violated the agency's sexual abuse policy. This staff person was immediately suspended during the administrative investigation and was terminated. This was evidenced by a review of the investigative file of this incident provided by the facility.

The facility reported that over the past 12 months there have been no staff from the facility who have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse). This auditor corroborated that through review of allegations reported over the past 12 months. During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that any staff that violated the agency sexual harassment policy (as well as the Employee Standards of Conduct) would be subject to commensurate disciplinary sanctions with input from the agency's contracting bodies. The PREA Coordinator confirmed that there had been no disciplinary action taken on staff who had been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse).

115.276(d):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, "All terminations for violations of agency policies relating to sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies."

The Facility indicated that in the past 12 months, there had been one staff that had been reported to law enforcement for violating the agency's sexual abuse or sexual harassment policies. This was evidenced by a review of the investigative file of this incident provided by the facility. This packet included a Barron County Sheriff's Department Case Report that detailed the notification made by the facility and subsequent criminal investigation that took place.

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

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 following evidence was analyzed in making the compliance determination:
1. Documents: (Policies, directives, forms, files, records, etc.)
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. Facility Director
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.277(a-b):
During the pre-onsite portion of this audit, the Facility provided LSS ARJ PREA Policy and Procedure in support of their compliance in this standard in its PAQ responses. The Policy establishes, “Contractors and/or Volunteers found to have engaged in sexual harassment, sexual misconduct, sexual abuse will be dismissed from services at any LSS ARJ facility.” The facility indicated that over the past 12 months, there had been no instances where contactors or volunteers had been reported to law enforcement agencies or relevant licensing bodies for engaging in sexual abuse of residents. During the onsite portion of the audit, this auditor interviewed the Facility Director. The Facility Director reported that BART does not have any contractors or volunteers.

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

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.278 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents: (Policies, directives, forms, files, records, etc.)
   a. BART PAQ responses
2. Interviews
   a. Agency Head/Designee

Findings:
115.278(a-g):
During the pre-onsite portion of this audit, the Facility response on the PAQ was non-applicable for this standard. LSS ARJ PREA Policy and Procedure establishes, "LSS ARJ programs have no ability to discipline a correctional client for sexual assault/harassment. However, the relevant correctional entity will be immediately contacted should a report be made about a client and removal requested at least during the investigation.
LSS ARJ programs have no ability to discipline a correctional client for making a false report. The relevant correctional entity would be contacted if the report is found to be false and although a recommendation would be made by the LSS program, any discipline would be up to the correctional entity."

During the onsite audit portion of this audit, this auditor interviewed the Agency Head/Designee. Per the Agency Head/Designee confirmed the Agency has no authority to sanction residents who engage in sexual abuse or harassment. All agency policies state the residents who engage in sexual abuse or harassment would be removed from the program. DOC would detain the resident pending their investigation and final disposition.

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

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
2. Interviews
   a. PREA Coordinator
   b. Security Staff and Non-Security Staff First Responders
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.282(a-d):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. The Policy establishes, “Victims of rape or sexual assault will be referred to the local hospital for physical assessment and documentation of injuries by a SANE nurse. This referral will occur in a timely manner, and will afford the victim unimpeded access to emergency medical treatment and crisis intervention services. Staff will transport the victim to the hospital, or accompany them if they are transported by the police, unless the alleged abuser is a staff member, then staff would only accompany the resident if requested, so as not to impede the investigation. The hospital staff will be requested to provide 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 at no cost, regardless of whether the victim names an abuser or cooperates with the investigation.”

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that all resident victims of sexual abuse would receive immediate and unimpeded access to emergency medical treatment and crisis intervention. The PREA Coordinated reported that any treatment would be at no cost to the resident. The PREA Coordinator indicated that the facilities would document the timeliness of the emergency medical treatment and crisis intervention services that were provided, the response by program staff that acted as first responders, and timely information and services concerning contraception and sexually transmitted infection prophylaxis. The PREA Coordinator indicated that the need for these records have never occurred as there has not been a reported instance of sexual abuse in this facility that the victim was taken to a local hospital. There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered.

During the onsite portion of this audit, this auditor interviewed security and non-security staff first responders. The facility indicated that all staff are the facility’s first responders. This auditor interviewed the staff and asked them about the first responder protocol. All staff indicated in the event they were the first to respond or learn of a sexual assault, they would call for additional staff, call 911, notify the on-call, separate the alleged victim and accuser, secure the scene, and arrange for medical care. As noted above, the facility has not had a report of sexual abuse in which a response was required. Having no medical or mental health practitioners on-site, the facility has evidenced a consistent procedure among security and non-security first responders the necessity to immediately take steps to protect the victim and notify medical and mental health practitioners.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all provisions of this 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. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. PREA Notice to Residents
   d. LSS ARJ Sexual Vulnerability/Predation Risk Assessment form
2. Interviews
   a. Security Staff and Non-Security Staff First Responders
   b. Case management staff
   c. PREA Coordinator
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.283(a-c):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor LSS ARJ PREA Policy and Procedure. The Policy establishes, “Medical staff at the local hospital are responsible for examination, documentation, and treatment of victim injuries arising from sexually abusive behaviors, including testing when appropriate for pregnancy and sexually transmitted infections, including HIV.

The forensic exam is performed by qualified sexual assault examiners (Sexual Assault Nurse Examiner). The victim is examined at a local hospital equipped to conduct such examinations. The forensic exam will occur as soon as possible, but within 72 hours of staff becoming aware that a resident reported involvement in a sexually abusive assault. A resident’s refusal of a forensic examination is documented in the resident record.

The facility will arrange follow-up care, including screening for infectious disease (HIV, viral hepatitis, or other sexually transmitted infections), pregnancy testing for female victims, and administration of prophylactic medication (if exposure to blood borne pathogens is suspected) if these services were not already rendered. The facility will also coordinate any referrals to mental health providers in the community for follow-up care to an incident. The services will be of no cost to the victim.”

There were no residents that the Facility classified as having reported sexual abuse. The auditor attempted to corroborate this report by reviewing confidential resident case files and during resident and staff interviews. No residents who reported a sexual abuse were discovered. During the onsite

portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that all resident victims of sexual abuse would receive access to community-based medical and mental health treatment. This auditor also interviewed two case management staff at this facility. These staff indicated that all residents, including those that have reported prior sexual abuse or victimization, are offered mental health services through community-based providers.

115.283(d)-(e):
During the pre-onsite portion of this audit, the Facility indicated that this provision was not applicable as the Facility only houses male residents.

115.283(f):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. As indicated in subsection (a-c) above the Policy includes testing when appropriate for pregnancy and sexually transmitted infections, including HIV. As noted in subsection (a-c) of this standard, the facility had one report of sexual abuse occurring in the facility, but it was reported after the resident left the Facility, therefore there was no medical or mental health documentation for this auditor to review.

115.283(g):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure and the PREA Notice to Residents. The PREA Notice to Residents states, “Treatment services shall be provided to the victim without financial costs and regardless of whether the victim cooperates with any investigation arising out of this incident.” As indicated in subsection (a-c) above of this standard, the facility had one report of sexual abuse occurring in the facility, but it was reported after the resident left the facility, therefore there was no medical or mental health documentation for this auditor to review. During the onsite portion of this audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that under no circumstances would LSS require a resident to pay for treatment services as a result of being a victim of sexual abuse. She further reported that LSS would not condition payment of these services on whether the victim names the abuser and/or cooperates with the investigation arising out of the incident.

115.283(h):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor LSS ARJ PREA Policy and Procedure .The Policy states that the facility shall attempt to conduct a mental health evaluation and treatment for all known resident-on-resident abusers.” During the onsite portion of this audit, this auditor conducted 14 resident file audits. The LSS ARJ Sexual Vulnerability/Predation Risk Assessment form screening form that was provided was evidenced to be utilized during the resident intake. The case file audit revealed no residents being identified as a known resident-on-resident abuser.

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

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   e. Documentation of criminal and administrative investigations
   f. Sexual abuse incident review documentation
2. Interviews
   a. PREA Coordinator
   b. Facility Director
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.286(a-e):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. The Policy establishes, “In the cases of unsubstantiated allegations, Executive Staff review the incident to assess the facility’s response to the allegations. Executive staff includes the ARJ Director, one or more ARJ Managers, and may include the ARJ Executive Director and the LSS Risk Management Director. All factors noted within PREA Standard 115.286(d) are considered. The PREA Compliance Manager at the location from where the report was filed documents the review in a report, including recommendations for improvements, if any. If the unsubstantiated allegation involved a staff member, the report under this section must not include the staff member’s personally identifiable information. The report is submitted to appropriate LSS staff, typically the HC Specialist and Program Supervisor, who ensures implementation of the recommendations or documents the reason for not following them.

In cases of substantiated sexual abuse, Executive Staff review the incident to assess the facility’s response. All factors noted with PREA Standard 115.286 (d) are considered. The PREA Compliance Manager documents the review in a report, including recommendations for improvements, if any. The report is submitted to the appropriate LSS staff, typically the HC Specialist, Program Supervisor and Manager, who ensures implementation of the recommendations or documents the reason for not following them. A copy of this report is forwarded to the Regional Director through the Regional PREA Coordinator.”

During the onsite portion of this audit, this auditor reviewed documentation of completed criminal and administrative investigations. This documentation reveals that the SART was comprised of Facility level management, investigative staff, and the PREA Coordinator. There are no medical or mental health staff at the Facility. This team reviewed the incident within 30 days of the conclusion of the investigation. The documentation also reveals that the SART includes the following review topics in its Sexual Abuse Response Team (SART) Report: 1) whether there are any recommendations for improvement of policy or practice; 2) whether the allegation and or incident was motivated by lesbian, gay, bisexual, transgender or intersex identification; 3) an examination of the area in the facility where the incident occurred to expose any potential physical barriers that may enable the abuse; 4) whether staffing levels were adequate in that area during all shifts; and 5) whether monitoring equipment/technology is sufficient to protect residents from sexual abuse and sexual harassment. There were no recommendations for improvement in the report reviewed. During the onsite portion of the audit, this auditor interviewed the Facility Director. The Director reported that all incidents of sexual abuse are reviewed by the PREA Coordinator. The Facility Director informed this auditor that the facility does not have any medical or mental health practitioners on staff. The PREA Coordinator reported that the SART always prepares a report indicating its findings, including any determinations made pursuant to this standard. The PREA Coordinator also reported that she is always a member of the SART; additionally, once the review has been completed, she is responsible for ensuring that the facility follows through and implements any corrective action developed.

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

Standard 115.287: Data collection

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

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
  ☒ Yes ☐ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. PREA Annual Reports
   d. Investigative Files
2. Interviews:
   a. PREA Coordinator
   b. Facility Director of Designee
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.287(a):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. This Policy establishes, “All reports of a PREA incident will be documented on a Significant Events Reporting Form by the Supervisor or Manager of the program within 24 hours of the incident being noted. The individual filing the initial SERF is responsible for updating the SERF in EVOLV regularly until such time that the incident disposition is complete. A standardized method Information is collected via SERF through EVOLV in order to make annual reports of incidents. All supporting documents are retained electronically.”

115.287(b):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. The Policy establishes, “LSS ARJ reviews data annually as well as during the incident review period to identify problem areas, taking corrective action on an ongoing basis, and prepares an annual report of its finding.” The Facility also provided this auditor with the Facility’s PREA Annual Report. This report includes an aggregated report listing all substantiated, unsubstantiated, and unfounded sexual abuse allegations reported in the past 12 months.

115.287(c):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with the Facility’s PREA Annual Report. The annual report included aggregate information on the types of incidents. The Facility provided this auditor with a monthly and annual report that tracked the daily population and total number of residents admitted and discharged. The facility collects aggregated data necessary to answer the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

115.287(d):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. A review of the criminal investigation file referenced in provision 286(a) reveals that the facility maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The investigation file includes each of those items.

115.287(e):
During the pre-onsite portion of this audit, the Facility indicated that this provision was not applicable as the agency does not contract with other entities for the confinement of its residents.
During the onsite portion of the audit, this auditor interviewed the Agency Head. The Agency Head reported that LSS does not contract with other private or public entities for the confinement of its residents.

115.287(f):
During the pre-onsite portion of this audit, the Facility indicated that this provision was not applicable as the agency reported the Dept. of Justice has not requested agency data.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with all applicable provisions of this 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*)

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. PREA Annual Reports (2019, 2020, 2021)
   d. Agency website
2. Interviews
   a. PREA Coordinator
   b. Agency Head
3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings:
115.288(a):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. The policy establishes, “LSS ARJ reviews data annually as well as during the incident review period to identify problem areas, taking corrective action on an ongoing basis, and prepares an annual report of its finding per 115.288 (a)-1. A report is filed annually (bi-annually for 2016) and is available on the website www.lsswis.org under the section Corrections/Restorative Justice.” The Facility also provided this auditor a copy of the Facility’s PREA Annual Report. The annual report included aggregate information on the various types of incidents.

During the onsite portion of this audit, the auditor interviewed the Agency Head and PREA Coordinator. The Agency Head reported that the PREA Coordinator keeps statistics. LSS reviews, analyzes and discusses trends annually. LSS also evaluate each reported allegation to determine if policy and practice is sufficient or could be improved. LSS considers training needs as well during that assessment. The PREA Coordinator reported that on an annual basis she reviews incidents that would qualify as Sexual Abuse/Harassment. This data is then utilized to create the PREA Annual Report. If certain incident(s) become more prevalent then they would be targeted and analyzed to ensure proper corrective measures are in-tact and or need strengthening including protocol assessment.

115.288(b):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and the PREA Annual Report indicates corrective actions taken and provides an assessment of the agency’s progress in addressing sexual abuse. This auditor was able to corroborate this report by reviewing prior years’ annual reports. However, although the agency has reported and sufficiently demonstrated that they evaluate key data pursuant to paragraph (a) of this standard, this provision requires that comparison be included in the current year’s data and corrective actions with those prior years in addition to an assessment of the agency’s progress in addressing sexual abuse. The comparison and the assessment must be included in the report. The 2019 and 2020 annual reports lacked a comparison of the current year’s data with those from prior years.

115.288(c):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided a link to the Agency’s website. A review of this website reveals that it contains a link to LSS’s Annual PREA Reports, as well as PREA audit reports and pertinent policies and procedures.,
During the onsite portion of the audit, this auditor interviewed the Agency Head. The Agency Head reported that he approves annual reports pursuant to this provision.

115.288(d):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and reported that, nothing is redacted. Comparing the 2020 Annual Report provided as part of this PREA audit to the 2020 Annual Reports available on the Agency’s website evidences the same report.
During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that nothing is redacted from the approved annual report prior to its publication on the Agency’s website.

Corrective Action:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (b) of this standard. The auditor and Agency agreed upon the following corrective action plan: The PREA Coordinator will ensure future annual reports to include a comparison of the current year's data with those from prior years and include an assessment of the agency's progress in addressing sexual abuse required by provision (b) of this standard.

On February 22, 2022, the PREA Coordinator informed the auditor that the Agency's 2021 Annual PREA Report was finalized and published on their website. This auditor accessed the website and reviewed the 2021 Annual Repost and confirmed it included a comparison of 2021 data to 2020 data as required by this standard.

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

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. BART PAQ responses
   b. LSS ARJ PREA Policy and Procedure
   c. PREA Annual Report
   d. Agency website
2. Interviews
   a. PREA Coordinator
3. Site Review Observations:
   a. Observations during on-site review of physical plant

Findings:
115.289(a):
During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with LSS ARJ PREA Policy and Procedure. The Policy establishes, "Regarding PREA specific information, the LSS ARJ policy is:
All incident-based and aggregate data regarding PREA events will be stored securely and electronically.
Procedures include:
• All reported incidents will be entered into EVOLV via a SERF report which will be updated regularly by the author of the report until such time as a final disposition is made
•The PREA Coordinator will maintain an electric file for each reported incident on the secure
H: drive and/or a secure email folder specific to that incident. The file or folder will include all documentation and communication regarding the incident up to and including the final disposition.
• Aggregated sexual abuse data from LSS ARJ PREA facility is made readily available to the public via the LSS website (www.lsswis.org) under the Corrections/Restorative Justice tab. The information will be updated in January each year. All personal identifiers are to be removed from aggregate data that is provided to the public.
• The data will be retained for at least 10 years from the date of initial collection. "

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that all data is securely retained on password secured computer data bases. While onsite, this auditor observed inactive staff computers. Each computer observed required a username and password to navigate. A review of this website reveals that it contains a link the Agency's Annual PREA Reports, as well as PREA audit reports that contain aggregated sexual abuse data and pertinent policies and procedures. The PREA Coordinator reported that any personal identifying information (PII) is not included and/or redacted from the annual report. A review of the agency's website and the annual reports publicly available, this auditor was able to confirm that personal identifiers have been removed. The PREA Coordinator reported the data will be retained for at least 10 years from the date of initial collection.

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

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☐ Yes ☒ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. LSS Website: https://www.lsswis.org/
   b. Prior PREA Audit Reports
2. Pre/Onsite/Post-Audit Observations
   a. General observations during the audit process

Findings:

115.401(a-b):
A review of the agency's website and prior Final Audit Reports revealed that the agency has six facilities falling under PREA standards. During the prior three-year audit period, the agency ensured that each facility it operates was audited at least once. This was the second PREA audit of BART.

115.401(h):
During the onsite portion of this audit, this auditor had access to, and the ability to observe, all areas of the audited facility. The facility provided this auditor with unfettered access to the facility and its staff and residents.

115.401(i):
During the pre-audit, onsite, and post-onsite portion of this audit this auditor was permitted to request and received copies of any relevant documents that this auditor requested, including but not limited to: facility logs, resident files, personnel files, policy and procedure manuals, postings, resident handbooks, intake and classification documents, etc.

115.401(m):
During the onsite portion of this audit this auditor was permitted to conduct private interviews with residents and staff at the facility.

115.401(n):
During the pre-audit potion of this audit residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

While onsite this auditor asked all residents interviewed whether they were made aware of and saw this auditor's notices that were displayed throughout the facility. All residents interviewed informed this auditor that the postings have been displayed.

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

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

The following evidence was analyzed in making the compliance determination:
1. Documents:
   a. LSS Website:
   b. Prior PREA Audit Reports
2. Interviews
   a. PREA Coordinator

Findings:
115.403(f):
A review of the Agency's website reveals that all Final Audit Reports were posted to its website within 90 days of its issuance by the auditor. LSS has an agency website and has a page dedicated to the posting or PREA-related information (www.lsswis.org/service/mental-health-and-addictions/aspen-center/prison-rape-elimination-act-prea/).

During the onsite portion of this audit, this auditor interviewed the PREA Coordinator informed this auditor that all Final Audit Reports are immediately posted on LSS's website.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this standard. The agency has a dedicated PREA page on its agency website that makes available not only Final Audit Reports to the general public but also its PREA policy, and its Annual Report.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Dave Andraska 2/24/2022

Auditor Signature **Date**