

PREA AUDIT REPORT Interim Final
COMMUNITY CONFINEMENT FACILITIES

Date of report: November 20, 2015

Auditor Information			
Auditor name: Bryan K. Henson			
Address: 778 Redbud Road Grand Rivers, KY 42045			
Email: bshenson@windstream.net			
Telephone number: 270 994-1825			
Date of facility visit: October 21-22,2015			
Facility Information			
Facility name: Morehead Inspiration Center			
Facility physical address: 1111 US Highway 60W, Morehead, KY 40351			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 606 783-0404			
The facility is:	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input checked="" type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Community treatment center	<input type="checkbox"/> Community-based confinement facility	
	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input checked="" type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
Name of facility's Chief Executive Officer: Tony White			
Number of staff assigned to the facility in the last 12 months: 7			
Designed facility capacity: 104			
Current population of facility: 85			
Facility security levels/inmate custody levels: Community			
Age range of the population: 21-72 years old			
Name of PREA Compliance Manager: Tony White		Title: Facility Director	
Email address: Tony.White@Pathways-Ky.org		Telephone number: 606 787-0404	
Agency Information			
Name of agency: Pathways Inc.			
Governing authority or parent agency: <i>(if applicable)</i> Pathways Inc.			
Physical address: 1212 Bath Ave. Ashland, Ky 41105			
Mailing address: <i>(if different from above)</i> PO Box 790			
Telephone number: 606 329 8588			
Agency Chief Executive Officer			
Name: Dr. Kimberly McClanahan		Title: Chief Executive Officer	
Email address: kmccclanahan@pathways-ky.org		Telephone number: 606 329-8588	
Agency-Wide PREA Coordinator			
Name: Henry A. White (Tony)		Title: MIC- Program Director	
Email address: tony.white@pathways-ky.org		Telephone number: 606 783-0404	

AUDIT FINDINGS

NARRATIVE

The site visit for the PREA Audit of the Morehead Inspiration Center was conducted on October 21-22, 2015. The audit was conducted by Bryan Henson, DOJ Certified PREA Auditor. During the Pre-audit phase, much of the file review was conducted prior to the site visit. During the on-site portion of the audit, any necessary file review follow-up was completed, we toured the facility and conducted formal staff and resident interviews. The auditor interviewed 10 residents, all 10 were random resident interviews. The facility indicated there were no residents identified as LBGTI, disabled, limited English proficient, or residents that had reported sexual abuse at the facility. In addition, the team interviewed 31 staff, including 20 specialized staff, 11 random staff (representing all shifts and various posts), the Acting Chief Executive Officer, the Facility Program Director, and the PREA Coordinator. The interviews covered PREA training, how to report, to whom to report, filing reports, available interventions, conducting interviews, evidence preservation protocol, follow up, and monitoring retaliation.

An entrance meeting was held at the beginning of our visit with the Facility Director Tony White, Acting CEO Shawn Conley, and Robyn Gray, SOS Coordinator/Nurse. There were 85 residents assigned to the facility on the date of the audit with a max capacity of 104. Following the entrance meeting, we toured the facility. In the past 12 months from September 2014 through August 2015, Morehead Inspiration Center reported there were no allegations reported of sexual abuse or sexual harassment at the facility.

Although the facility PREA policy covers language for all standards that have a policy mandate, it is strongly recommended that the PREA Coordinator conduct a review of the PREA policy and consider adding additional detail to better support many of the other PREA standards to assist and better guide staff in their continuous readiness and response to allegations of sexual abuse and sexual harassment.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Morehead Inspiration Center is a long-term residential recovery program for adult men seeking recovery from substance abuse. The program is six to nine months. This is a nonprofit organization and an affiliate of the Recovery Kentucky initiative. The Morehead Inspiration Center serves a population of 100 adult men who are housed in either 2-man rooms or an open bay setting, and offers four levels of recovery which incorporate a social model of recovery, peer support, accountability, daily living skills, job responsibilities, and practical living experiences. Morehead Inspiration Center incorporates the 12 steps with Recovery Dynamics classes, and life skills classes to educate the addict/alcoholic about their disease.

SUMMARY OF AUDIT FINDINGS

An exit meeting was held at the end of day two to brief the Executive Staff of the general findings of the audit to date. The site visit found the staff and residents to have a good general awareness of what PREA was about. They were very aware of reporting methods and responsibilities, as well as the means to safeguard victims of sexual abuse and/or sexual harassment.

Although the facility still has areas that are evolving and maturing with PREA, this writer felt a very conducive environment for reporting and believes the facility is moving in a positive direction with PREA.

Number of standards exceeded: 1

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

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

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

Facility Policy includes zero tolerance language and details required facility approach to prevention, detection, and response to sexual abuse and sexual harassment. Although the training curriculum and reporting form has a set of definitions of prohibited behavior, recommend these definitions be added to the facility PREA policy. The facility director serves as the PREA Coordinator.

Standard 115.212 Contracting with other entities for the confinement of residents

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

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Contract/RFP from October 2013 between Pathways, MIC and KYDOC includes language(pg 4) to obligate the facility to adopt and comply with PREA Standards.

Standard 115.213 Supervision and monitoring

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

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Facility policy requires the facility to conduct an annual assessment of the staffing plan. After a review of the staffing plan, I found that the staffing plan was well developed, and that it documented all necessary components to provide adequate staffing as called for in the standard. The staffing plan also included an annual assessment of the 2014 staffing plan to consider necessary adjustments. The Contract with Ky DOC requires a specific list of staff to ensure adequate staffing. A review of sample schedules supports that adequate staff required by the contract is being provided.

Standard 115.215 Limits to cross-gender viewing and searches

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

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The facility policy prohibits person searches of any type by MIC staff. Policy also prohibits cross gender strip searches at the facility. Any potential searches of transgender/intercross residents would be conducted by KY DOC P&P staff and done so in accordance with DOC policy. DOC P&P staff assigned to MIC have been trained on these type searches. Facility Policy enable residents to shower, perform bodily functions, and change clothing in private. Also, policy requires staff of opposite gender to announce themselves when entering restroom area or resident apartment. Interviews from both staff and residents indicate that female staff rarely enter these areas and when they do, they are compliant.

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

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

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The PREA Handout given out to all residents at orientation upon arrival was available in a format accessible to all residents. The facility does not rely on resident interpreters, but does have outside interpretive services available. All residents interviewed understood what PREA was, as well as reporting mechanisms and their rights.

Standard 115.217 Hiring and promotion decisions

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

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recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Pathways policy requires the Human Resource Department to secure a criminal background check on all potential new hires and contractors. It also covers background checks of current staff and contractors at least every 5 years. A review of 5 random personnel files reflected that prehire backgrounds checks had been conducted. It should be noted that MIC does not currently have services provided by contractors. A check shows that employees with more than 5 years service have had a check conducted within the past 5 years. The facility has a form signed by all applicants (potential new hires) and employees (seeking promotions) to ensure they are asked about previous misconduct. Occurrences of sexual harassment are taken into consideration when determining whether or not to promote a staff member. The human resources supervisor confirmed that upon request from another institution, information on substantiated allegations of sexual abuse and harassment involving a former employee would be provided.

Standard 115.218 Upgrades to facilities and technologies

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

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Facility policy supports standard. The facility reported there had been no renovations or new buildings, as well as no changes in video monitoring since 2012.

Standard 115.221 Evidence protocol and forensic medical examinations

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

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The facility training curriculum outlines and follows evidence protocol and that protocol required is followed by Kentucky DOC and Kentucky State Police. No incidents have occurred that required sending a resident out for a forensic exam. Policy supports offering victims access to forensic exams at no cost to the victim. Also that attempts to provide the exam by a SAFE/SANE and document such attempts. The facility is included in an MOU between KDOC and KASAP(Pathways Victims Advocate Services) that provide victim advocates services to MIC. Also, 2 staff at MIC have been trained to serve as victim advocates should the need arise. In section (f) there was documentation in a letter from Kentucky State Police, who is responsible for conducting criminal investigations of sexual abuse, that they would comply with sections (a-e). As a recommendation, the evidence protocol should be placed in the agency policy.

Standard 115.222 Policies to ensure referrals of allegations for investigations

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

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

Facility policy ensures all allegations of sexual abuse and sexual harassment are referred for investigation, to include those with the legal authority to conduct criminal investigations and document such referrals. The facility website does indicate that all allegations are referred to KDOC and KSP and their responsibility for criminal investigations. It also includes the responsibility of MIC Investigators.

Standard 115.231 Employee training

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

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

Reviewed training curriculum and it meets each component of standard. Training records and Staff interviews indicate required training was completed and properly documented.

Standard 115.232 Volunteer and contractor training

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

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The facility policy supports the standard in that all volunteers and contractors are trained in the appropriate PREA topics. A review of the training handout and the completion/acknowledgements forms signed by each of the volunteers demonstrates compliance. Interviews of volunteers support that training has been conducted. They report there are no contractors currently working at MIC.

Standard 115.233 Resident education

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

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

A review of resident PREA handout indicates it covers all necessary components of standard 233 (a). It is provided in a format accessible to all residents. Residents do sign an acknowledgement that they received PREA education and understand what they received. Interviews of residents support documentation. Key information is evident continuously in areas accessible to all residents throughout facility.

Standard 115.234 Specialized training: Investigations

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

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

The facility investigators as well as KY DOC P&P investigators have received required training in conducting investigations. The documentation supporting their completion was reviewed. The investigation curriculum was reviewed for such training and meets the requirements of section (b).

Standard 115.235 Specialized training: Medical and mental health care

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

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

The facility has one medical staff member and no mental health care staff that work in the facility. The one medical staff has had training required by 115.231, and has recently completed the KDOC PREA Specialized Medical/Mental Health training and provided a certificate of

completion for that. The training curriculum has been reviewed and meets all components of the standard.

Standard 115.241 Screening for risk of victimization and abusiveness

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

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

The Risk screening tool used meet all components of section (d)(e). A check of sample screenings conducted in the past 12 months, as well as resident interviews indicate that the intake screenings are completed within the 72 hours. Documentation provided indicates that the facility is reassessing the residents risk levels based upon any additional, relevant information within 30 days of arrival. There is no evidence of inappropriate discipline toward residents, and there are appropriate controls of the responses to the screening tool as they are securely maintained in the office of the SOS Coordinator.

Standard 115.242 Use of screening information

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

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

The facility reports that to date no residents at MIC have been assessed at high risk for victimization or abusiveness. Program Director makes all housing decisions, and approves all program decisions that include work assignments within the Recovery KY Programming. He maintains a spreadsheet that is set up with color coding to enable him to use the screening information to inform any housing decisions. A daily log that tracks program and work assignments and requires the Director to sign each day approving such assignments after giving consideration to Risk Screening Information. All rooms and dorms are equipped with individual showers to allow for all to shower separately. Interviews support that transgender/intersex residents, if present, would have input to their own safety and no designated facilities are set up for LBGTI residents.

Standard 115.251 Resident reporting

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

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

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

The facility provides multiple internal ways for residents to report incidents, i.e. any staff member, complaint form to be mailed anonymously, given to a staff member, or slipped under a staff member's door, etc.. Residents may also report outside of the agency to the PREA Hotline that goes to the KY DOJ Investigative Branch. A test call was conducted on the PREA Hotline and was connected and received properly. Staff are required to accept reports in any form and document such reports. Staff have methods in place to privately report incidents to include a hotline. The facility had a very conducive reporting environment.

Standard 115.252 Exhaustion of administrative remedies

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

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The facility does have a complaint system that allows resident to file related to sexual abuse/harassment. The facility PREA policy indicates there are no timelines for any complaints related to sexual abuse. The complaint system does not require the resident to submit it or responded by the involved staff member. Director verbally indicated that 3rd party may assist in these type complaints. This system allows for immediate response/action when the alleged incident could result in sentinel events or serious physical/mental injury. No residents were disciplined as a result of filing a complaint for sexual abuse/harassment. There were no grievances/complaints filed regarding sexual abuse or sexual harassment within the past 12 months. Recommend that the Suggestion and Complaint Report system be included in the orientation to formally inform residents of this option to report. Also, recommend that the policy that guides the complaint report system provide more detail to better support the standard.

Standard 115.253 Resident access to outside confidential support services

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

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

Residents are provided with outside victim advocate (Pathways Rape Victims Services Program) with a toll free number and address. MIC is included in an MOU that has been established for confidential services between KASAP(KY Ass. Of Sexual Assault Programs) and Ky DOC. Flyer is posted that contains all contact information and informs residents of extent of communication monitoring by facility and the extent of mandatory reporting required by Victim Advocate.

Standard 115.254 Third-party reporting

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

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Third parties may call the PREA Hotline number that is posted on the Agency Website. <http://www.pathways-ky.org/residential.html>

Standard 115.261 Staff and agency reporting duties

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

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Facility PREA policy (page 4, 7b) requires staff reporting as outlined in standard. All staff are required to report immediately any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment, retaliation against residents or staff who reported an incident and any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation. Staff interviews showed good general knowledge of their duties and responsibilities in reporting. The medical screening assessment has a statement that requires staff to inform residents of practitioners duty to report such information regarding sexual abuse allegations/incidents. Director White is adding a statement to also inform on the PREA Risk Screening Form.

Standard 115.262 Agency protection duties

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

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Facility PREA policy uses direct language from this standard. Staff interviews show good knowledge of their responsibility of protecting residents who were at risk of imminent sexual abuse.

Standard 115.263 Reporting to other confinement facilities

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

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

Facility PREA policy uses language that supports the standard as all components are included. The facility reports no instances of this occurring. No documentation was available for review.

Standard 115.264 Staff first responder duties

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

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Facility PREA policy, training curriculum, and the coordinated response written plan all support the standard. The facility directs all staff to take appropriate measures as first responders. Staff interviews showed good general knowledge of the first steps taken as a first responder.

Standard 115.265 Coordinated response

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

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The facility does have a written plan that coordinates actions in response to allegations of sexual abuse that includes first responder, medical/mental health practitioners, investigator, and facility leadership response. All facility potential first responders have read and understood the plan.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

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

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The agency has not entered into any collective bargaining agreements that would restrict or limit the agency's ability to remove alleged staff sexual abusers from any contact with residents.

Standard 115.267 Agency protection against retaliation

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

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The facility PREA policy provides language to ensure monitoring for retaliation as required in the standard. The training curriculum and staff interviews indicate that the Program Director and the SOS Director are designated to monitor retaliation. The facility has reported no cases that would have required retaliation monitoring within the past 12 months.

Standard 115.271 Criminal and administrative agency investigations

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

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The facility policy supports the standard as it states all allegations are referred for investigations. All sexual abuse investigators have received specialized investigator training as outlined in standard 115.234. The Program Director and SOS Director are both designated to be the facility investigators and have received such specialized training. Interviews of facility investigators show they have knowledge of the investigative process and support all components of standard. The facility reported that they have received no allegations of sexual abuse or sexual harassment in the past 12 months.

Standard 115.272 Evidentiary standard for administrative investigations

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

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Investigator interviews showed knowledge possessed of this requirement. Recommend adding language in PREA policy to help support this standard.

Standard 115.273 Reporting to residents

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

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The facility is compliant based upon interviews support required reporting and policy indicates many of the required areas are to be reported to resident victims. There were no reported incidents within the past 12 months that would have required reporting to a resident victim. Recommend that areas excluded in policy that are required to be reported, be added to the PREA policy. Also recommend developing a notification form to be used for all required resident notifications required of this standard.

Standard 115.276 Disciplinary sanctions for staff

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

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

Facility PREA policy supports standard. The facility reported no staff have received disciplinary sanctions of any type for violating agency PREA Audit Report

sexual abuse and/or sexual harassment policies.

Standard 115.277 Corrective action for contractors and volunteers

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

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

Although interviews support that contractors and volunteers are subject to similar corrective actions as staff, the policy only addresses staff. Staff are not defined in the policy provided. The facility reported no occurrences of where a contractor or volunteer was reported to law enforcement or relevant licensing bodies. Staff interviews showed remedial measures are in place that would restrict contact between contractors and/or volunteers who have allegedly committed sexual abuse or sexual harassment towards residents. Recommend that Section 11 under Disciplinary in the PREA policy, add contractors and volunteers.

Standard 115.278 Disciplinary sanctions for residents

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

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

Facility Program guidelines clearly outline disciplinary action (program dismissal) toward a resident that has been found to have engaged in sexual abuse toward another resident. The facility reported no occurrences of resident-on-resident sexual abuse within the past 12 months.

Standard 115.282 Access to emergency medical and mental health services

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

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

Facility policy allows for resident victims to receive timely, unimpeded access to emergency medical treatment and crisis intervention services at no cost to the victim. The facility had no occurrences reported that would require such treatment during the last 12 months.

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

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

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

Facility PREA policy supports the standard indicating that evaluations are offered to victims as deemed appropriate and refers for testing of sexually transmitted infections when requested. The medical screening form asks residents when they arrive about prior sexual abuse and if they respond with a yes, they are offered the appropriate medical/mental health evaluation. Also, policy states that both medical and mental health services will be provided on a on-going basis. Recommend adding to this section that these services are provided at no cost to the resident.

Standard 115.286 Sexual abuse incident reviews

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

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

The facility is complaint with this standard as the PREA policy supports the standard (pg 6 10a), and they have a form developed to conduct Incident Reviews that covers each component of the standard. They did not have any incidents in the last 12 months, therefore no I/Rs were required. However, they did have a substantiated case in April of 2014 and the designated team did conduct the required review.

Standard 115.287 Data collection

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

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

corrective actions taken by the facility.

The facility does collect data accurate, uniform data for each allegation, and is reported to KY DOC. All reports required from this standard is maintained. The instrument used to collect the data includes a set of definitions. Currently, the facility data is aggregated annually on the Ky DOC Website. Although the facility reports there were no incidents in the past 12 months, there were 2 allegations/incidents in 2014 that were aggregated and placed in the KY DOC Annual Report.

Standard 115.288 Data review for corrective action

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

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

After a review of the 2014 PREA Annual Report, it documents that the facility/agency has reviewed aggregated data in order to improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training including identifying problem areas, taking corrective actions on an on-going basis and preparing an annual report of its findings and corrective actions. The facility reports that there were no allegations in the past 12 months; however, there were two incidents/allegations in 2014 that were reviewed to meet the requirements of section (a) of this standard. The Annual Report for 2014 is posted on the Pathways/MIC website and is readily available to the public.

Standard 115.289 Data storage, publication, and destruction

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

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

The facility PREA Coordinator reported that all data collected is securely retained in the Directors Office. The aggregated data contained in the PREA Annual Report is made readily available on the agency/facility website.

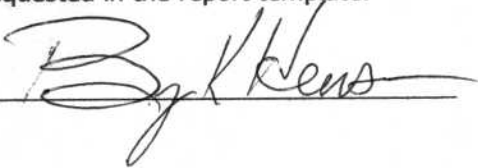
AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

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

Bryan K. Henson



Auditor Signature

November 20, 2015

Date