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

☐ Interim  ☒ Final

Date of Report

Auditor Information

Name: Kayleen Murray  Email: kmurray.prea@yahoo.com

Company Name:  Click or tap here to enter text.

Mailing Address: P.O. Box 2400  City, State, Zip: Wintersville, Ohio 43953
Telephone: 7403176630  Date of Facility Visit: November 4-5, 2019

Agency Information

Name of Agency: MonDay Community Correctional Institution

Governing Authority or Parent Agency (If Applicable):
MonDay Facility Governing Board

Physical Address: 1951 S. Gettysburg Ave  City, State, Zip: Dayton, Ohio 45417

Mailing Address: 1951 S. Gettysburg Ave  City, State, Zip: Dayton, Ohio 45417

The Agency Is:
☐ Military  ☐ Private for Profit  ☒ Private not for Profit
☐ Municipal  ☐ County  ☒ State  ☐ Federal

Agency Website with PREA Information:  Click or tap here to enter text.

Agency Chief Executive Officer

Name: Michael Flannery
Email: flannerym@mcohio.org  Telephone: 937-496-3002

Agency-Wide PREA Coordinator

Name: Ruby Galpin
Email: galpinr@mcohio.org  Telephone: 937-496-3008

PREA Coordinator Reports to:

Michael Flannery

Number of Compliance Managers who report to the PREA Coordinator: 1
## Facility Information

<table>
<thead>
<tr>
<th>Name of Facility:</th>
<th>MonDay Community Correctional Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Address:</td>
<td>1951 S Gettysburg Ave</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Dayton, Ohio 45417</td>
</tr>
<tr>
<td>Mailing Address (if different from above):</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Click or tap here to enter text.</td>
</tr>
</tbody>
</table>

- **The Facility Is:**
  - [☐] Military
  - [☐] Private for Profit
  - [☐] Private not for Profit
  - [☒] State
  - [☐] Federal
  - [☐] Municipal
  - [☐] County

- **Facility Website with PREA Information:**

- **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): Bureau of Community Sanctions
  - [☐] N/A

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

### Facility Director

<table>
<thead>
<tr>
<th>Name:</th>
<th>Michael Flannery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td><a href="mailto:flannerym@mcohio.org">flannerym@mcohio.org</a></td>
</tr>
<tr>
<td>Telephone:</td>
<td>937-496-3002</td>
</tr>
</tbody>
</table>

### Facility PREA Compliance Specialist

<table>
<thead>
<tr>
<th>Name:</th>
<th>Ruby Galpin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td><a href="mailto:galpinr@mcohio.org">galpinr@mcohio.org</a></td>
</tr>
<tr>
<td>Telephone:</td>
<td>937-496-3008</td>
</tr>
</tbody>
</table>

### Facility Health Service Administrator

- **N/A**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Click or tap here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Telephone:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Facility Characteristics</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Designated Facility Capacity:</td>
<td>260</td>
</tr>
<tr>
<td>Current Population of Facility:</td>
<td>248</td>
</tr>
<tr>
<td>Average daily population for the past 12 months:</td>
<td>252</td>
</tr>
<tr>
<td>Has the facility been over capacity at any point in the past 12 months?</td>
<td>☒ No</td>
</tr>
<tr>
<td>Which population(s) does the facility hold?</td>
<td>☒ Both Females and Males</td>
</tr>
<tr>
<td>Age range of population:</td>
<td>18-62</td>
</tr>
<tr>
<td>Average length of stay or time under supervision:</td>
<td>140 days</td>
</tr>
<tr>
<td>Facility security levels/resident custody levels</td>
<td>minimum</td>
</tr>
<tr>
<td>Number of residents admitted to facility during the past 12 months:</td>
<td>672</td>
</tr>
<tr>
<td>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:</td>
<td>607</td>
</tr>
<tr>
<td>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:</td>
<td>531</td>
</tr>
<tr>
<td>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)?</td>
<td>☒ Yes</td>
</tr>
<tr>
<td>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):</td>
<td>Federal Bureau of Prisons, U.S. Marshals Service, U.S. Immigration and Customs Enforcement, Bureau of Indian Affairs, U.S. Military branch, State or Territorial correctional agency, County correctional or detention agency, Judicial district correctional or detention facility, City or municipal correctional or detention facility (e.g. police lockup or city jail), Private corrections or detention provider, Other - please name or describe: Click or tap here to enter text.</td>
</tr>
<tr>
<td>Number of staff currently employed by the facility who may have contact with residents:</td>
<td>118</td>
</tr>
<tr>
<td>Number of staff hired by the facility during the past 12 months who may have contact with residents:</td>
<td>44</td>
</tr>
<tr>
<td>Number of contracts in the past 12 months for services with contractors who may have contact with residents:</td>
<td>6</td>
</tr>
<tr>
<td>Number of individual contractors who have contact with residents, currently authorized to enter the facility:</td>
<td>6</td>
</tr>
<tr>
<td>Number of volunteers who have contact with residents, currently authorized to enter the facility:</td>
<td>52</td>
</tr>
</tbody>
</table>

**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.

| Number of buildings: | 2 |

**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.

| Number of resident housing units: | 5 |

**Number of single resident cells, rooms, or other enclosures:**

| Number of single resident cells, rooms, or other enclosures: | 8 |

**Number of multiple occupancy cells, rooms, or other enclosures:**

| Number of multiple occupancy cells, rooms, or other enclosures: | 0 |

**Number of open bay/dorm housing units:**

| Number of open bay/dorm housing units: | 56 |

**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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are medical services provided on-site?</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Are mental health services provided on-site?</td>
<td>☒</td>
<td>☐</td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>Criminal Investigations</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
<td>0</td>
</tr>
</tbody>
</table>
| 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 |

<table>
<thead>
<tr>
<th>Administrative Investigations</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>6</td>
</tr>
</tbody>
</table>
| When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply | ☒ Facility investigators  
☐ Agency investigators  
☐ An external investigative entity |
| Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations) | ☐ Local police department  
☐ Local sheriff's department  
☐ State police  
☐ A U.S. Department of Justice component  
☐ Other (please name or describe: Click or tap here to enter text.)  
☒ N/A |
Audit Findings

Audit Narrative

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

The PREA onsite visit for MonDay Community Correctional Institution located at 1951 S. Gettysburg Ave in Dayton, Ohio was performed November 4-5, 2019. The goal of the audit is to ensure operational compliance with the Prison Rape Elimination Act (PREA) standards for community confinement facilities.

The facility elected send emails to provide the auditor with documentation relevant to showing compliance with each standard. The auditor the information was available approximately six weeks prior to the onsite visit. The information included the pre-audit questionnaire, policy and procedures, MOUs, facility staffing plan, table of organization, job descriptions, and post orders. The auditor received photos showing proof of audit notices posted in resident and staff areas six weeks prior to the onsite visit. The auditor has conducted the audit for this agency in 2017. The auditor reviewed the prior final audit report and previous documentation for comparison to the current audit.

The audit notice posting was sent to the auditor showed the dates of the onsite visit; the name, address, and email address of the auditor; and the ability to have confidential correspondence with the auditor. The auditor did not receive any correspondence from residents or staff prior to the onsite visit. The auditor did not receive any request to speak with the auditor during the onsite visit.

In addition to the documentation sent prior to the onsite visit, the auditor reviewed ten resident files, ten staff files, staff and resident training records, risk for abusiveness screenings and re-screenings, agency website, acknowledgement forms, posters, brochures, floor plan with camera locations, volunteer/contractor information, and coordinated response plan during the onsite visit.

The onsite visit was conducted over two days where the auditor received a complete tour of the male and female buildings and perimeter areas. The tour included observations of the housing units, dorm rooms, bathrooms, closets/storage rooms, administration area,
and outdoor recreation area. During the walkthrough, the auditor was able to have informal conversations with both staff and residents. The auditor made notes of cameras, security mirrors, blind spot areas, and staff/resident interaction. The auditor was provided a private office to conduct formal interviews with staff and residents.

The auditor interviewed twenty residents based on the population of two hundred forty-eight residents during the onsite visit. The residents selected were based on the requirements of the PREA Resource Center’s Auditor Handbook guidelines. The residents were selected based on their housing unit, targeted interview status, risk assessment screening, intake dates, and commitment status. The auditor conducted the following interviews:

- Random = 16
- Targeted = 4

The breakdown of the number of targeted interviews is as follows:

- Residents that identify as lesbian, gay, or bisexual = 4
- Residents that have a physical or cognitive impairment = 1
- Resident that reported prior sexual victimization during risk screening (at another confinement facility) = 1
- Residents that identify as transgender or intersex = 1

*Some targeted residents fit into more than one targeted category and were interviewed on all specialized and random interview protocols.

The auditor conducted the interviews in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook Guide for Effective Strategies for Interviewing Staff and Residents. The auditor explained the interview process to each resident and that they were under no obligation to answer questions. The auditor asked questions concerning the resident’s experience with PREA education, allegation reporting requirements, retaliation, staff communication, grievance reporting, knock and announcements, searches (pat, enhanced pat, strip, body cavity, and cross-gender), housing unit concerns, limits to confidentiality, outside supportive services, disciplinary sanctions, and other PREA related concerns.

The facility has one hundred eighteen full and part-time staff members including the Director. The auditor was able to talk with agency leadership, specialized interviews, and random staff members during the onsite visit, which includes:

PREA Audit Report, V5 Page 7 of 127 Facility Name – double click to change
The auditor also interviewed twelve random staff members from both programming and security. Security staff from both shifts were interviewed. Several staff members were responsible for more than one specialized area.

All staff interviews, random and specialized, were conducted using the PREA Compliance Audit Instrument Interview Guide and the PREA Auditor Handbook’s Effective Strategies for Interviewing Staff and Resident Guide. The auditor was able to question staff on the agency’s zero tolerance policies, trainings, reporting protocols, first responder duties, coordinated response plan, grievance procedures, investigation protocols, confidentiality, retaliation monitoring, risk screening, protection from abuse, LGBTI policies and procedures, data collection, annual reports, staffing plans, electronic surveillance, reporting to other confinement facilities, disciplinary procedures, knock and announcements, cross-gender supervision polices, and transgender/intersex accommodations.

The auditor reached out to the facility’s community resources by email to confirm the MOUs and scope of services. These community partners include representatives from Montgomery County Victim Witness Department and Miami Valley Hospital. The auditor was able confirm the services of the hospital would provide to residents free of
charge. The hospital partners with the Montgomery County Victim Witness Department and confirmed the services that agency would provide. The auditor received an email from the Montgomery County Victim Witness Division’s Director who listed the services the agency provides free of charge.

On the final day of the audit, the auditor sat down with agency and facility leadership to review preliminary audit findings.

Facility Characteristics

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

MonDay Community Correctional Institution is a community based correctional facility located in Dayton, Ohio that serves both male and female felony offenders.

The MonDay Community Based Correctional Facility is located in Dayton, Ohio and serves adult male and female felony offenders. The facility consists of two separate buildings, one for male residents and one for females. In order to access the secure perimeter of the facility one must report to the male resident building 1, be signed in by a receptionist, and sign a zero tolerance policy acknowledgment. Residents will enter at the intake entrance and receive a pat down or a strip search. The intake area also has a single use shower that can be used to allow transgender residents to shower privately.

During the 2017 PREA audit, Female residents also processed through the intake area in building one. The facility has since move the female intake process to the Delta building which has eliminated the need for females to be processed in the same building.

Building 1 contains the kitchen/dining area, commercial laundry, outdoor rec area, staff offices, group rooms, a library, medical, and male orientation housing unit. The clinician offices are located around the dayroom and all have windows with clear line of site views inside. The library from the dayroom has open hours but only one resident is allowed in for 30 minutes at a time. The commercial laundry is visible to the dayroom floor through a wall of windows and also has a camera inside. All group rooms in this area have windows in the doors and cameras inside. A registered nurse and a contracted doctor
staff the medical area. Two psychiatrists visit the facility to provide services to the residents.

The dining and kitchen areas have adequate camera coverage. The facility has installed a camera to cover a blind spot area that leads to a staff restroom within the kitchen based on a recommendation from the previous PREA audit. Residents work in the kitchen under the direction of staff and are escorted into stock room areas. The stock room has a camera inside, the cooler has a window in the door, and the cage area has a window in the door and a camera. The dock and maintenance areas are off from the kitchen and have camera coverage.

The facility has three male housing units. The male housing unit in building 1 houses orientation residents. Residents are housed here for approximately 21-30 days. The dorm floor of building 1 has a night watch desk with a camera that can record audio and video. The camera is focused on the desk area and cannot see into the dorm or bathroom areas. This housing unit has a total of three dorms each set up the same. Each dorm area is divided into two pods by a half wall. The dorm areas have an open doorway with a locker area set up as the designated changing area. The facility has cameras in the dorms but no views into the changing area. The cameras in the dorm areas have no active views to the various monitors in the facility. Supervisory staff complete spot checks and female staff have no access. Residents that have been designated as vulnerable would be placed in a dorm and bed that is easily visible from the night watch desk. The three bathrooms in this housing unit are set up the same. The bathrooms have open doorways, non-reflective mirrors, two toilet stalls, and three single use shower stalls. Curtains that have clear tops and bottoms or have been cut to see feet cover the toilets and showers. Cameras that have views into the shower record to a separate server with no active views. Only the operations director, operations coordinator, and operations supervisors have limited access. No female staff have permission to view this area.

Building 2 (described as building two but is connected to building 1) contains administration, main post, resident entrance/exit, patio areas, elevator, indoor recreation area/visitation room, staff kitchen, group rooms, clinical hallway, library, outdoor recreation area, and two housing units. The clinical hallway and administration area are off limits to residents without a staff escort. Residents will not have individual counseling sessions in this area if there is only one staff working in the clinical hallway. Cameras cover the hallway areas. The facility elevator provides access to this area but staff and residents are not allowed to ride in the elevator together and residents can only ride one at a time. The indoor recreation area has a basketball court with a walking track above. Residents are provided with rec time twice a day for 30 minutes.
both male and females are held in the indoor recreation area. Staff will escort female resident to building two where the court will be divided into male and female sections. There are camera views of the entire court and staff supervision. The outdoor recreation area is surrounded by a 20ft curved fence and has camera surveillance. Resident Leaders supervise residents while in this area. All group rooms have windows in the doors and cameras in the rooms. Residents in building 2 eat in building 1. The residents are escorted down a hallway that has access to the dining area. At no time do the residents interact with the orientation residents housed in building 1.

Building 2 has two housing unit areas. Residents are separated into housing units based on Ohio Risk Assessment System (ORAS) score. One housing unit in building 2 has dorms with cameras that records both audio and video and security mirrors. The doors on the dorms have windows in the door and are locked during program hours. At night, the doors are propped open. This housing unit also has several two-person rooms. The bathroom in this housing unit has non-reflective mirrors, toilets, and showers. Shower curtains that have clear tops cover the toilets and showers. The shower area has a scissor gate at the entrance to the area and is locked during programming hours. Resident still have access to the toilet area. Residents must get permission from the Resident Leader staff before entering the bathroom. Residents must sign in/out to use the restroom and only four residents can occupy the bathroom at any one time. The housing unit has a covered patio area for resident use with permission from staff. The second housing unit mirrors the first and also has security mirrors and cameras that record both audio and video. All housing units have the ability to “buzz” the main post to contact security staff.

The females are housed in Delta building. This facility is on the same campus but in a different building than the male facility. Staff must unlock the door for entrance into the facility. The facility is divided into two sections. One section contains space for offices and group rooms. During the daytime hours, all residents are moved to one wing for program activities. There is a recreation area that is enclosed by a fence and requires staff supervision while in use. The laundry room, group rooms, and offices all have windows in the doors and camera inside. The segregation cell is used to conduct strip searches. There is a camera in the room that focuses on the staff member. There is a restroom inside the segregation cell where the resident will stand so as not to be viewed by the camera. The library located in this building is locked until the facility can place a camera inside. Staff can view the cameras in this building from the Team Leaders office but cannot see the cameras located in the male building. The dining area is set up in day room area and food that is prepared in the male facility is brought to the female facility by staff.
The housing unit in the female facility has several sleeping pods. The pods are divided into rooms and sleep two-three residents per room. There are no doors to the rooms and the windows have been tinted. The pods each share a bathroom that contains a single use toilet and shower covered by a curtain. Since the facility’s last PREA audit, the facility has added cameras to the dorms.

The facility (both male and female buildings) have put in place several strategies to prevent, detect, and respond to sexual abuse and sexual harassment. The facility has placed security mirrors in strategic places to minimize blind spot areas; have an electronic key card system in the male facility; and provide residents with a way of contacting staff from inside the dorm if necessary. MonDay's electronic surveillance program includes 115 cameras placed throughout the male facility (interior and exterior) and 85 cameras placed throughout the female facility (interior and exterior) that have the capability to record and playback up to 30 days. Some cameras are omni directional and have the capability to record audio as well as video. Camera footage is viewed by Resident Leader staff assigned to the main control post. Cameras that have views to sensitive areas cannot be seen at control post and require permission to access. These recordings are stored on a separate server with only administrative access. Supervisory staff have access to the facility camera system on their office desk top computer. Resident Leader staff are required to conduct three security checks per shift and every half-hour after lights-out. During a count, staff must document physically seeing each resident. Identified blind spot areas have increased circulation.

**Summary of Audit Findings**

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

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

**Standards Exceeded**

- Number of Standards Exceeded: 0
- List of Standards Exceeded: Click or tap here to enter text.

**Standards Met**

- Number of Standards Met: 42
115.261, 115.262, 115.263, 115.264, 115.265, 115.266, 115.267, 115.271, 115.272, 115.273, 115.276, 

**Standards Not Met**

- **Number of Standards Not Met:** 0
- **List of Standards Not Met:** Click or tap here to enter text.
Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?  ☒ Yes  ☐ No
- Does the written policy outline the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment?  ☒ Yes  ☐ No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator?  ☒ Yes  ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy?  ☒ Yes  ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?  ☒ Yes  ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

MonDay Community Correctional Institution policy 3.9 states that the facility will provide a safe, humane, and appropriately secure environment, free from the threat of sexual abuse or harassment for all residents by maintaining clear procedures for reporting, detecting, responding, and investigating sexual abuse or harassment.
policy also prohibits retaliation against persons who report sexual abuse or harassment. The policy includes definitions for sexual abuse, sexual harassment, voyeurism, substantiated, unsubstantiated, unfounded, LGBTI, and gender non-conforming.

Policy 3.9.1 outlines how the facility will prevent, detect, and respond to allegations of sexual abuse and sexual harassment. This includes having a PREA Coordinator who has sufficient time and authority to develop, implement, and oversee the facility’s efforts to comply with the Federal PREA Standards.

The facility provided the auditor with the PREA Coordinator’s job description. The job description list the duties as:

- Coordinates, oversees, and plan the facility’s adherence to the PREA standards
- Managing and maintaining the facility’s accreditation through PREA
- Maintaining all files and data entry for compliance with accreditation process
- Provides advice, support and assistance by interpreting policies and procedures
- Writes and/or reviews on all new and revised policies to ensure compliance with standards and best practices
- Keeps informed with changes in standards and laws
- Acts as a liaison between the facility and PREA
- Take disciplinary action whenever necessary to ensure the effectiveness and integrity of the program
- Identifies and coordinates the training needs of staff to ensure compliance with all applicable accreditation standards

During the onsite visit, the auditor was able to interview with PREA Coordinator. She is the facility’s Accreditation Manager and reports directly to the Director. She reports that she is responsible for ensuring that staff have everything they need in order to comply with the standards. She works with the Director to make sure proper policies and procedures are in place and identifies areas where the facility needs to improve based on data collected for the annual report and staffing plan.

The facility also has a PREA Compliance Specialist. The Specialist is responsible for the day-to-day compliance efforts of the facility. She ensures staff, contractors, volunteers, and residents receive appropriate training; assist with ensuring proper housing, programing, and educational programs for identified residents; retaliation monitoring; administrative investigations, and any other area identified by the PREA Coordinator.
The Coordinator and Compliance Specialist state they have sufficient time and authority to implement the processes necessary to comply with the standards.

During the onsite visit, the auditor spoke with the agency Director. The Director reports that he depends on the PREA Coordinator as well as the PREA Compliance Specialist to ensure that the facility has the proper policies, procedures, and protocols in place in order to comply with the standards. He states that he takes the recommendations of the Coordinator and works with management staff and the budget to implement those recommendations.

MonDay has appropriate policies and procedures in place to comply with the PREA Standards and a PREA Coordinator and Compliance Specialist that have sufficient time and authority to develop, implement, and oversee the agency’s efforts to comply with the standards.

Review:
Policy 3.9 and 3.9.1
Interview with PREA Coordinator
Interview with PREA Compliance Specialist
Interview with Director

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

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

**115.212 (a)**

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

**115.212 (b)**

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

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

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

N/A: The PREA Coordinator reports that the facility does not contract with other facilities to house residents.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? ☒ Yes ☐ No

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

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

**115.213 (b)**

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

**115.213 (c)**

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

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

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

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.
Agency policy 3.9.1 requires each MonDay to develop and document a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect residents against sexual abuse. The policy requires the plan to be reviewed on an annual basis and assess whether adjustment are needed regarding staffing patterns and monitoring techniques.

The facility provided the auditor with their most recent staffing plan. The staffing plan includes a detailed floor plan for both buildings with camera locations, staffing plan deviation report, annual average daily population, and the prevalence of substantiated and unsubstantiated sexual abuse reports. The facility reports that it has not deviated from the staffing plan.

The facility has one hundred fifteen (115) cameras in the male building and eighty-five (85) in the female building. Both buildings have “PREA cameras” that are located in dorm rooms and in the male building night watch office. These cameras do not have a live view to Central Control and can only be accessed by supervisors with approval. Supervisors of the opposite gender will not have access to the “PREA cameras” of that opposite gender. The identified “PREA cameras” are only accessed when needed during an investigation. During the onsite visit, the auditor was able to view the cameras located in central control in both buildings. The monitors did not have a view into the dorm areas. A supervisor for each gender showed the auditor how to log into the system and provide a password for access to the same gender “PREA cameras.” The “PREA cameras” for the opposite gender does not show as an option. Cameras throughout both buildings have the capability of a 90-day playback and records audio.

The PREA Coordinator reports that the facility has very few vacancies. The facility has not deviated from the staffing plan that was developed based on a population of two hundred fifty male and female residents. She reports that should a Resident Leader (RL) call off work, another RL would stay or would be called in to work. If necessary, program or management staff can assist with maintaining appropriate staffing levels. The Resident Leader shift plan is as follows:

- 0600-1800 minimum RL staff = 6 male building and 2 female building
- 1800-0600 minimum RL staff = 6 male building and 2 female building

Resident Leader Supervisors work 1100-1900 in order to assist with both shifts. Male Resident Leader staff do not work in the female building.
Resident leaders conduct security checks. RL staff are required to conduct four rounds per shift and four counts. Two counts are conducted bedside and two are conducted on the floor. A perimeter check is conducted at least once per shift.

The facility provides transportation of residents to community activities. The facility tries to ensure same gender transportation; however, if that is not feasible or if there is both a male and female resident that need to be transported, the agency requires the staff to transport in a facility vehicle that has a camera inside. The staff member will ensure there is a seat in between a male and female resident if they need to be transported at the same time.

The auditor reviewed the allegations from the past year with the PREA Coordinator and the PREA Compliance Specialist. The facility had one substantiated sexual abuse allegation. The SART team did not make any recommendations based on the review of the investigation. The team did review an unfounded allegation that was determined not to be PREA but did include a recommendation. The recommendation was approved by the Director and implemented. The recommendation included not allowing staff to use a bathroom that is directly off the dayroom.

During interviews with agency leadership, they discussed their ongoing process of reviewing each building for ways they can prevent, detect, and respond to incidents of sexual abuse and sexual harassment. The staff spoke of applying for grants from the State of Ohio. The grants have allowed the agency to increase the number of cameras in both buildings.

The annual staffing plan is completed annually by the PREA Coordinator and approved by the agency Director.

Review:
Policy and procedure 3.9.1
Staffing plan FY 2020
Floor plan
Camera monitors
Building tour (male and female)
Interview with agency investigators
Interview with PREA Coordinator
Interview with Director
Interview with PREA Compliance Specialist
Interview with Duty Director
**Standard 115.215: Limits to cross-gender viewing and searches**

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

**115.215 (a)**

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

**115.215 (b)**

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

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

**115.215 (c)**

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

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

**115.215 (d)**

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

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

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

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 3.9.1 outlines the agency search procedures. The policy prohibits cross-gender pat, strip, and visual body cavity searches except when performed by medical personnel. All nonmedical staff are restricted from viewing the breast, buttocks, or genitalia of residents of the opposite gender when the residents are showering, performing bodily functions, or changing clothing. This includes via video camera.

All residents entering the secure perimeter of the facility will receive a pat or strip search by a staff member of the same gender. The pat search is conducted on camera. Residents
who receive a strip search will be moved to a designated room where a camera will be able to view the staff member but not the resident. During the onsite visit, the auditor toured the strip search room in both the male and female building and viewed the room via camera monitor in central control. The room is appropriately set up to view staff on camera but allow privacy for the resident.

The auditor watched pat searches of males and females while at the onsite visit. The searches were conducted in accordance with protocols discussed with the auditor by the Operations Coordinator.

The policy does not allow for transgender/intersex residents to be searched for the sole purpose of determining a resident’s genital status. Searches are to be conducted in a professional and respectful manner and in the least intrusive manner possible. The facility currently has a transgender resident. The PREA Coordinator and PREA Compliance Specialist report discussing security, safety, and manageability protocols with Ohio’s Bureau of Community Sanctions PREA Liaison prior to placement and consulting with the resident on pat search gender preference. The auditor interviewed the resident. The resident stated that she was consulted concerning safety, preferences, and privacy. She states that all pat searches have been completed by her preferred gender and have been completed respectfully and professionally.

As part of supportive documentation, the auditor reviewed the training curriculum provided to staff members who are responsible for conducting pat searches. The training is conducted by the Assistant Operations Coordinator and includes instructions on appropriate pat search techniques for cross-gender and transgender searches, respectful communication with LGBTI residents, and how to conduct a pat search in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs.

The facility allows residents to shower, perform bodily functions, and dress in areas not viewable to staff. The facility has a restroom in each of the housing units for residents to be able to shower and use the toilets. Policy 3.9.1 requires all staff to announce their presence when entering an area where residents shower, perform bodily functions, and change clothing. All non-medical staff are prohibited from viewing a resident’s breast, buttocks, or genitalia except in exigent circumstances or when such viewing is incidental to routine security checks. The facility requires all residents to change in the bathroom in order to ensure the most private space for changing clothing.
The male dorm rooms are set up with a designated changing area. Residents are required to change in this area due to the dorms having cameras. The designated changing areas have an opening off the dorm area and surrounded by resident lockers. The lockers are tall enough to block the view from the cameras. Each dorm has signage instructing residents to only change clothing in the designated area. Residents who are housed in dorm rooms that are set up without designated changing areas, must change in the bathroom. The female residents are required to change in the bathroom shower area behind a curtain.

The bathroom in the male dorms are divided into a toilet/sink area on one side and a shower area on the other. During programing hours, the shower area is closed off via a scissor gate and residents must request a pass from the Resident Leader to use the bathroom. There is a solid door at the bathroom entrance that is usually propped open. No one can see the toilet or shower area from outside the bathroom. The bathroom on the second floor housing unit has six toilets with curtains at each entrance and four urinals with partitions between each. To the right of the entrance is the shower area. There are seven individual shower stalls with a curtain at the entrance. The male bathroom on the first floor housing unit is set up exactly the same as the second floor. The third male housing unit has dayroom and offices on the first floor and dorms and bathroom on the second floor. There is a toilet room on the first floor that residents use during programing hours. There are three bathrooms in the dorm area. All bathrooms have large openings at the entrance. There are three individual showers and two or three toilets. All are covered by a curtain.

*The curtains that surround the shower stalls in each of these bathrooms in this housing unit are not approved PREA curtains. The facility has already ordered shower curtains that have clear tops and bottoms. The PREA Compliance Specialist provided the auditor with a paid invoice for the appropriate curtains.*

The bathrooms in the female housing units are attached to dorm units. There is one bathroom for two dorms. Each dorm houses between two/three residents. On one side of the entrance to the bathroom/dorm area is a single use shower with a curtain and on the other side is the toilet and sink also covered by a curtain. During programing hours, there a specific bathroom available for resident use. The dorm rooms that are attached to this bathroom are closed with a scissor gate. The transgender resident has a private dorm area and does not have to share a bathroom with other residents.

The facility also has holding cells with toilet areas. There is one holding cell in the male facility that does not allow for the resident to use the bathroom in the most private
manner as possible. There is a window to the door of the holding cell that offers a clear line of site view to the toilet area (the window is small and not at eye level). The PREA Compliance Specialist reports that the facility has other holding cells that offer a more private area to use the toilet and that would be the cell that they would use when needed. She reports that the holding cells are primarily used during intake and the use of the cell in question is not needed.

Monday policy 3.9.1 requires staff of the opposite gender to announce their presence when entering a resident housing unit. Staff will again announce their presence when entering a dorm area of the opposite gender. The auditor was able to see this in practice during the tour portion of the onsite visit.

During the onsite visit, the auditor was able to interview twenty (20) residents. The auditor inquired about searches as well as cross-gender announcements. All of the residents interviewed have received at least one pat search and one strip search during their stay at the facility. Male residents interviewed stated that they have never been pat or strip searched by a female staff member. They report that pat and strip searches have been professional and respectful. The residents report that when female staff come onto the floor that they always announce their presences. They state that the dorm room doors are locked during programming hours but then the dorms are open, female staff announce their presence before entering. The residents state that they are not allowed to change in their room because of the cameras. Female residents that were interviewed state that it is very rare to have a male staff member on the floor. They state that when male staff are in the building, they tend to stay in the housing area. Should a male staff member or a member of maintenance need to be in the dorm or bathroom area, the area is cleared of all residents before the male can have access. No female resident reported being searched by male staff member. The residents report understanding the facility’s dress policy and the requirement to change in the bathroom.

The auditor conducted Resident Leader (RL) interviews from both shifts and from each building. All staff interviewed indicated that they received annual training on how to conduct proper pat searches, strip searches, and transgender searches. The staff report that they are prohibited from conducting cross-gender searches and body cavity searches. When questioned about searching transgender residents. The staff report that they have had several transgender residents throughout the years and are totally comfortable conducting respectful and professional searches.

The auditor interviewed the Operations Coordinator and the Assistant Operations Manager during the onsite visit. Both supervise Team and Resident Leaders. They state
that they train and conduct quality control observations of searches. They report search training techniques include appropriate communication when conducting searches and using the back of the hand in erogenous zones. Staff review a pat search video produced by the Ohio Department of Rehabilitation and Corrections.

The facility’s policy, procedures, practice, training, and physical layout ensure that all residents are provided an appropriate, professional, and respectful pat or enhanced pat search, as well as providing them areas where they can privately shower, perform bodily functions, and change clothing.

Review:
Policy 3.9.1
Facility tour
Interview of target residents
Interview of random residents
Interview of staff
Interview of PREA Coordinator
Interview of PREA Compliance Specialist
Interview of Operations Coordinator
Interview of Assistant Operations Coordinator

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)
☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Policy 3.9.1 ensure that residents with disabilities (such as those who are deaf or hard of hearing; blind or have low vision; or have intellectual, psychiatric, or speech disabilities) have equal opportunity to participate in or benefit from all aspect of the agency’s efforts to prevent, detect, and respond to sexual abuse or sexual harassment. The policy also requires the facility to ensure that residents who have limited English proficiency, are deaf, or have other disabilities are able to report sexual abuse and harassment to staff directly through nonresident interpreters or interpretive technology.

The PREA Coordinator and PREA Compliance Specialist report that during intake, staff will review resident rules and regulations, including information about the facility’s zero tolerance policy. If the resident identifies or has known limited reading and/or comprehension skills, the staff will read the information aloud. If the resident is LEP, deaf, or disabled, the facility would make arrangements for an appropriate interpreter. The Coordinator reports that the agency works with VOCA link for access to interpreters. The facility has closed captioned, Spanish, and videos create for a third-grade reading/comprehension level as educational tools to ensure all residents know and understand how to prevent and report incidents of sexual harassment and sexual abuse.
The policy does not allow for the use of resident interpreters unless circumstances are such as where an extended delay in interpretation could compromise a resident’s safety, the performance of first-responder duties, or the investigation of the resident’s allegation of sexual abuse or sexual harassment.

The auditor was able to interview the staff member that performs resident intakes during the onsite visit. The instructor states that he will give them facility specific information regarding PREA and how to report allegations and answer any questions. He reports that he will read all paperwork to ensure all residents are able to understand the material and the expectations of the program during their stay. If the resident cannot read, has limited reading ability, or has comprehension issues, the RS states he will read the entire intake packet and explain each section. The instructor discussed the process for assisting residents who have been identified as needing an interpreter or auxiliary aids. He states that prior to placement, the facility would receive notice that a resident will need the assistance of an interpreter or auxiliary aids in order to participate in the program. The necessary assistance from VOCA will already be arranged. Residents that are deaf or hard of hearing and blind or have low vision that do not already have auxiliary aids will be provided them free of charge. The instructor also states that for residents with reading or cognitive issues the facility has a video that explains the agency’s PREA policies, practices, and protocols at a third-grade level.

The facility reports that they have not had a resident in need of interpreter services or auxiliary aids since the last PREA audit.

The auditor interviewed any resident that identified as having a reading or cognitive disability. No resident in this targeted category were in need of any additional services in order to benefit from the agency’s effort to prevent, detect, or respond to sexual abuse or sexual harassment. All residents interviewed were capable to describing the facility’s zero tolerance policy, reporting options, and services that are provided free of charge to any resident that request such services.

Review:
Policy 3.9.1
Resident intake materials
Interview with target residents
Interview with PREA Coordinator
Interview with PREA Compliance Specialist
Interview with PREA resident educator
Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

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

115.217 (c)

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

☒ Exceeds Standard (Substantially exceeds requirement of standards)
☐ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*

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

**Instructions for Overall Compliance Determination Narrative**

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

MonDay policy 3.9.1 prohibits hiring or promoting anyone who may have contact with the residents and prohibits the 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; has been convicted or engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied treats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described in the above section.

This policy also states that the facility must consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

Policy 3.9.1 requires the agency, before hiring new employees who may have contact with residents, to:

- Perform a criminal background records check
- Make its best effort 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.

Contractors and volunteers are also subject to a criminal background check prior to having contact with residents.

The policy requires employees to receive a criminal background records check every five years of current employees and contractors.
The auditor interviewed the Human Resources Manager during the onsite visit. The manager states that every five years the Human Resource Department will run background checks on the entire facility regardless when a person was hired in order to guarantee all staff received the required updated check (unless the employee/contractor was hired in that year). She states that she is responsible for conducting background checks for contractors and volunteers as well.

Policy 3.9.1 states that MonDay shall ask applicants and employees who may have contact with residents directly about previous sexual misconduct as described in this policy during interviews for hiring or promotion and in any interviews or written self-evaluations conducted as part of reviews of current employees. The facility imposes upon employees a continuing affirmative duty to disclose such misconduct.

The Human Resource Coordinator reports that during applicant interviews, each potential employee will be questioned on any allegations (civil or criminal) of sexual abuse and sexual harassment. The question is also documented on the applicant interview form. Employees who are applying for a promotion or different position, will have an interview and will also be questioned on any civil or criminal sexual abuse or sexual harassment allegations. The manager reports that an employee’s disciplinary record (write-ups or disciplinary actions) will be reviewed as part of the promotion process. The manager reports that any material omissions or provision of materially false information is grounds for termination. Currently employees must annually sign an affirmation of the facility’s zero tolerance policy.

The manager states that the facility will contact all previous employers for all successful applicants. The facility will seek information from all previous institutional employers on any substantiated sexual abuse or sexual harassment allegations or if the applicant resigned in the middle of an investigation of an allegation of sexual abuse or sexual harassment. The manager documents whether or not a potential employee has been found to have substantially sexually abused an offender or resigned during a pending investigation of an allegation of sexual abuse.

The agency documents any request from outside confinement facilities requesting PREA reference checks on potential employees. The manager reports no request at this time.

The auditor conducted a review of ten randomly chosen employee’s files and confirmed the background checks (initial and five-year update), documentation of the continual affirmation to disclose any sexual misconduct, referral checks, and disciplinary records. All files reviewed had the appropriate documentation to show compliance with this
standard. The agency also provided documentation of background checks for contract employees.

The auditor conducted an interview with the Human Resource Coordinator who took the auditor through the hiring and promotion process. The Manager states that during the hiring process, applicants are questioned about criminal or administrative sexual misconduct allegations during the interview. Once hired, all new employees are provided the agency’s zero tolerance policy and continued affirmation policy to disclose misconduct is done annually. Employees document their acknowledgment of this annually. The Manager reports that the facility will post positions internally for five days before the position is offered to outside individuals. Interested employees must complete an application, be interviewed, and undergo another criminal background records check. The department will review the employees file including disciplinary actions. Employees with disciplinary action that includes sexual misconduct are not eligible for promotion.

The agency makes every effort to ensure the facility does not hire nor promote anyone that has engaged in sexual misconduct.

Review:
Policy 3.9.1
Employee files
Continued affirmation
Prior institutional referral
Applicant interview questions
Background checks
Promotion documentation
Disciplinary records
Interview with Human Resources Manager

**Standard 115.218: Upgrades to facilities and technologies**

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

115.218 (a)

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

115.218 (b)

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

**Auditor Overall Compliance Determination**

- ☒ Exceeds Standard *(Substantially exceeds requirement of standards)*
- ☐ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

>The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Director reports that the facility has not acquired any new facility nor is it planning any substantial expansion or modification to the current facility.

The Director reports that the facility has increased the number of cameras in the facility since the last audit, including a camera recommendation made by this auditor. The Director reports placement of cameras in the female dorms has increase the facility’s ability to prevent, detect, and respond to incidents of sexual abuse and sexual harassment. The facility has also installed a camera in a facility vehicle that is used to facilitate cross-gender transports.

The Director will continue to monitor and address technology monitoring issues as needed.

**Review:**

New Cameras
Interview with Director

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

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

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

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

### 115.221 (e)

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

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

### 115.221 (f)

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

### 115.221 (g)

- Auditor is not required to audit this provision.

### 115.221 (h)

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

**Auditor Overall Compliance Determination**

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

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

- ☐ Does Not Meet Standard (*Requires Corrective Action*)
Instructions for Overall Compliance Determination Narrative

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The PREA Coordinator states that any allegation of sexual abuse or sexual harassment will be administratively investigated by a trained internal PREA investigator, and when necessary, criminally investigated by the agency with legal authority to conduct such investigation. The agency has provided the auditor with certificates for the administrative investigator training for all agency investigators. The facility has tried to enter into an agreement with the Montgomery County Sheriff’s Department but has not received a response.

Agency policy 3.9.2 requires the facility to investigate allegations of sexual abuse 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.” A complete copy of the publication is maintained by the PREA Coordinator. MonDay follows uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol includes:

- Protections for victims from threats of imminent harm
- Provisions of medical care for victims (for acute injuries and health concerns related to the abuse such as risk of HIV/AIDS, sexually transmitted infections, and pregnancy)
- Collection of forensic evidence from victims, which may aid investigations
- Preliminary documentation and investigation (which may lead to criminal charges against suspects, prosecution, and conviction, as well as administrative findings of sexual abuse, a formal disciplinary process, and/or disciplinary sanctions)
- Support, crisis counseling, information, and referrals for victims as well as advocacy to ensure victims receive appropriate assistance

The facility has six appropriately trained administrative investigators. The PREA Coordinator or the Assistant Director, both trained investigators, will conduct administrative investigations when allegations are made against staff members.
The facility does not provide forensic medical exams. Any resident in need of a forensic medical exam will be transported to Miami Valley Hospital. The hospital will use a certified Sexual Assault Nurse Examiners (SANE) of Butler County. The hospital partners with the jurisdictional law enforcement and victim/witness agencies.

Miami Valley’s Emergency Trauma Center clinical nurse provide the auditor with the hospital’s policy on Sexual Assault Forensic and Medical Examination. The protocol covers but is not limited to:

- Consent for forensic examination
- Sexual assault/abuse evidence collection procedures
- Documentation of injuries
- Photographic documentation of injuries
- Screen for potential drug facilitated sexual assault
- Maintaining chain of custody
- Evaluation and recommended treatment for HIV, pregnancy and sexually transmitted infection
- Working with law enforcement on medical issues pertinent to investigation of the crime

The clinical nurse reports that all services are provided to the victim free of charge.

The PREA Coordinator the facility has access to four Crisis Counselors that have been trained to serve as an emotional support person. The auditor was provided training certificates for all Crisis Counselors.

RECOMMENDATION:
The facility has four qualified clinicians that are trained as emotional support staff. The Montgomery County Prosecutor’s Office has a victim/witness services division that provides advocate services. This standard prohibits the use of that agency for emotional supportive services. The YWCA of Dayton, Ohio does have sexual assault services. The facility would benefit from entering into a Memorandum of Understanding with this agency. This would allow residents the option of receiving crisis support from outside the agency.

FACILITY RESPONSE:
The PREA Compliance Specialist reports that the facility has contacted the YWCA of Dayton, Ohio in order to enter into a Memorandum of Understanding. The YWCA has
agreed to provide the facility with rape crisis and emotional support services. The services will include:

- Use of agency’s hotline number and address
- Emotional support and counseling
- Victim advocacy
- Crisis intervention
- Support groups
- Information & referral
- Full-service wrap around clinical services

All services will be offered free of charge to the residents.

Review:
Policy 3.9.2
MOU attempts
SANE protocol/policy
YWCA of Dayton, Ohio website
Interview with PREA Coordinator
Telephone interview with Emergency Trauma Center clinical nurse

**Standard 115.222: Policies to ensure referrals of allegations for investigations**

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

115.222 (a)

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

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

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

**115.222 (c)**

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

**115.222 (d)**

- Auditor is not required to audit this provision.

**115.222 (e)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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Policy 3.9.2 requires MonDay to ensure allegations of sexual abuse or sexual harassment are referred to the Montgomery County Sheriff’s Office or the Dayton Police Department who have the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The investigation policy is posted on the agency’s website.

The auditor reviewed the agency’s website (https://www.mcohio.org/government/county_agencies/monday/prea.php) to ensure that the investigative policy for PREA allegations was posted. The website advises that all
allegations of sexual abuse will be referred to the local legal authority for a criminal investigation. The website also gives notice that all allegations (criminal or not) will have an administrative investigation conducted by a trained investigator.

The PREA Coordinator reports that sexual abuse allegations will receive an administrative investigation at the conclusion of a criminal investigation. The criminal investigatory agency will make referral to the local prosecutor for any allegation deemed appropriate according to their agency policy.

The facility has had twelve allegations reported during the past twelve months. During the onsite visit, the auditor reviewed the investigation with the administrative investigators (PREA Coordinator and PREA Compliance Specialist).

Investigation #1: A resident reported to a staff member that a Resident Leader called him a “queer” in a rule violation. The administrative investigator reviewed the rule violation and interviewed the staff member. The investigator determined that the issue was a language barrier due to the staff member having English as a second language. The resident agreed. The allegation was determined to be unfounded.

Investigation #2: A resident accused a staff member of sexual harassment. The administrative investigator was able to review the video and audio of the incident and determine that that incident as described did not happen. The allegation was determined to be unfounded.

Investigation #3: The facility received a report from a staff member of suspicious behavior between a resident and a staff member. The administrative investigator reviewed camera footage and interviewed the alleged abuser and victim. The victim did admit to kissing the staff member once. The allegation was determined to be substantiated. The staff member was terminated but the allegation was not referred due to the behavior not meeting the standard of criminal.

Investigation #4: A resident accused a staff member of trying to pursue a relationship with her. An administrative investigator reviewed the video and interviewed the alleged witness and victim. The evidence was unable to corroborate the allegation. The allegation was determined to be unsubstantiated.

Investigation #5: A resident accused a staff member of exposing himself while using a single use resident restroom. The video showed that the staff member using the restroom did not fully shut the door when using the bathroom. The view into the room with the
door not fully shut does not allow for anyone to see the staff member. The allegation was determined to be unsubstantiated; however, the staff member was disciplined for the incident. The facility also made it a violation for staff to use resident restrooms.

Investigation #6: A resident accused another resident of exposing him while showering and made sexualized comments. The administrative investigator interviewed the alleged abuser and victim and determined the allegation to be substantiated. The behavior was not criminal and therefore was not referred for a criminal investigation.

Investigation #7: A resident accused two other residents of exposing him while using the toilet. The administrative investigator interviewed the alleged abuser and victim and determined the allegation to be substantiated. The behavior was not criminal and therefore was not referred for a criminal investigation.

Investigation #8: A resident accused two other residents of make sexual comments and advances. The administrative investigator interviewed the alleged abusers and victim as well as a reviewed video evidence. The investigator determined the allegation to be unsubstantiated.

Investigation #9: A resident was accused of making sexually explicit comments to several residents. The administrative investigator interviewed the alleged abusers and victim as well as a reviewed video evidence. The investigator determined the allegation to be unsubstantiated.

Investigation #10: A resident was accused of making a sexual gesture toward another resident. The administrative investigator interviewed the alleged abusers and victim as well as a reviewed video evidence. The investigator determined the allegation to be unsubstantiated.

Investigation #11: A resident was accused of making a sexualized comment toward another resident. The administrative investigator interviewed the alleged abusers and victim as well as a reviewed video evidence. The investigator determined the allegation to be unsubstantiated.

*Investigation #12: The facility received information from the Dayton Police Department that a resident while in the emergency room, made an allegation of sexual abuse against a staff member. The police interviewed the alleged abuser. The staff member was never arrested and no charges have been filed. The resident was not returned to the facility after the hospital visit due to being combative in the hospital. Resident was returned to
the county jail. The PREA Coordinator conducted an administrative investigation and determined that the incident did not happen; however, has not receive the information necessary from the Dayton Police Department to close the investigation. The facility is considering this an open investigation until the police department confirms that the case is closed or some other action is taken.

Review:
Policy 3.9.2
Agency website
Investigation reports
Interview with administrative investigators
Training and Education

Standard 115.231: Employee training

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

115.231 (a)

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

115.231 (b)

- Is such training tailored to the gender of the residents at the employee’s facility? ☒ Yes ☐ No
Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Agency policy 3.9.3 requires the facility to ensure all employees that have contact with residents are trained (pre-service and in-service) on:

- The facility’s zero tolerance policy for sexual abuse and sexual harassment
- How to fulfill their responsibilities under MonDay’s sexual abuse and sexual harassment prohibition, prevention, detection, reporting, and response policies and procedures
- Residents’ right to be free from sexual abuse and sexual harassment
• The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment
• The dynamics of sexual abuse and sexual harassment in confinement
• The common reactions of sexual abuse and sexual harassment victims
• How to detect and respond to signs of threatened and actual sexual abuse
• How to avoid inappropriate relationships with residents
• How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents
• How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities

These training topics are taught to new employees during the onboarding process. All staff are required to attend this training before the employee can work directly with residents. The training is developed for both male and female genders and all staff are trained on both protocols.

The facility uses Relias online training to ensure employees that have contact with the residents receive the required training. The facility provided the auditor with the training curriculum from the online training. The subjects covered include:

• Purpose of PREA
• The PREA National Standards to Prevent, Detect, and Respond to Prison Rape
• Dynamics of Sexual Abuse Unique to Correctional Facilities
• Characteristics of Vulnerable populations
• Why Staff get Involved with People in Jail/Prison
• Master Manipulator
• Physical Signs of Potential Sexual Abuse
• Non-physical Signs of Potential Sexual Abuse
• Common Reactions of Victims in Confinement
• Your Powers of Observation
• Assess Your Knowledge
• Vital to Safety
• Special Populations: LGBTI
• Disclosure
• Be Respectful
• Verbal Communication
• Personal Biases
• Maintain Professional Boundaries
• Pitfalls to Avoid
• How to Protect Yourself from Liability

In addition to the required training dictated by the standard, the facility also provides training on the following related topics:

• Policy and procedure
• Confidentiality (limits and mandated reporting)
• Resident abuse
• Resident grievance
• Code of ethics
• Trauma Informed Care for Non-clinical Staff

The agency requires employees to take this online training every year. Employees also have the ability to take additional PREA trainings offered through the Relias online training system. The facility provided the auditor with course completion records which documents training completed by employees.

During staff interviews, staff stated they receive training on PREA standards and practices. They state that annually they have mandatory PREA training through Relias and also receive facility specific information regarding reporting, first responder duties, and documenting incidents. The staff felt the training was sufficient enough that they could effectively

The staff also discussed a PREA Staff Guide Book that is located at all post desk. The auditor reviewed the contents of the book. It includes:

• Sexual Abuse/harassment reporting form
• Coordinated respond plan with contact names and phone numbers
• PREA policies and procedures
• Retaliation Monitoring form
• PREA definitions
• Investigation report form
• Retaliation monitoring form
• SART review form
• Facility safety plan
• Risk assessment/reassessment form
The Organizational Development Specialist discussed the agency’s training practices. She states that the agency cross trains all staff concerning PREA gender specific topics because staff can work with male and/or female residents. She states that she tracks PREA training through the Relias system and that any additional trainings that relate to PREA are manually entered into the system based on the curriculum and sign-in sheet provided. She states that she will contact supervisors with reminders for staff who have not completed the mandatory PREA training.

Review:
Policy 3.9.3
PREA training curriculum
Course completion records
Interview with Organizational Development Specialist
Interview with staff

**Standard 115.232: Volunteer and contractor training**

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

**115.232 (a)**

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

**115.232 (b)**

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

**115.232 (c)**

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

**Auditor Overall Compliance Determination**

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

☒ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Policy 3.9.3 states that MonDay ensures that all volunteers, interns, and contractors who have contact with residents have been trained on their responsibilities under MonDay’s sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The level and type of training provided will be based on the services they provide and level of contact they have with residents.

The PREA Compliance Specialist reports that all volunteers, contractors, and interns watch a video specifically designed for them. The video was produced by the Ohio Department of Rehabilitation and Corrections. The auditor reviewed the training material for contractor training and signed acknowledgments.

There were no contractors on duty during the onsite visit.

Review:
Policy 3.9.3
Contractor/volunteer training video
PREA acknowledgement form
Interview with PREA Compliance Specialist

Standard 115.233: Resident education

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

115.233 (a)

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

During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

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

115.233 (b)

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

115.233 (c)

Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No

Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No

Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No

Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No

Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

☒ Exceeds Standard (Substantially exceeds requirement of standards)
☑ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*

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

**Instructions for Overall Compliance Determination Narrative**

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

MonDay policy 3.9.3 states that during the intake process, residents are given information explaining MonDay’s zero tolerance policy regarding sexual abuse and sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents.

Resident education will be made available in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills. In addition to providing such education, MonDay ensures that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats, such as brochures.

The auditor received a copy of the intake packet that all residents receive. The packet includes the resident handbook that provides information on the program rules which includes possible sanctions for violating the facility’s zero tolerance policy; reporting options including anonymous reports; third-party reporting options; investigation policies; free treatment options (medical, mental health, advocate services); and risk screening information. Residents will sign an acknowledgement of receiving this information and the acknowledgement will be placed in the resident’s file.

The auditor reviewed ten resident files while at the onsite visit. The auditor ensured that all ten files showed documentation that the residents received this information at intake.

During the onsite visit, the auditor noted various posters in English and Spanish throughout the facility. The posters provided information to residents, visitors, and staff on how to report allegations and phone numbers and address to reporting agencies. The auditor used the payphone in the dayroom to call the outside reporting agency. The phone number listed connected the auditor with a PREA hotline recorded message that
requested certain information in order to investigation the allegation. The recording reminded the caller that they could report anonymously and that all allegations would be investigated. The facility also has an email system that residents can use to send an email to report incidents of sexual abuse and sexual harassment. The system has a “PREA button” that gives the resident information on how to use the system to report an allegation.

The Intake Resident Leader is responsible for providing residents with PREA education during intake and the resident receives additional information during resident orientation. The RL provides facility specific information for reporting allegations; accessing medical, mental health, and rape crisis organizations; and locations of PREA information posted throughout the facility. The facilitator reports to the auditor that during orientation he reviews resident expectations, program rules, how to complete various forms, limits to confidentiality, the grievance process, and third-party reporting.

The auditor interviewed twenty residents (targeted and random) during the onsite visit. The residents interviewed stated that at intake they received a handbook, resident intake packet, and received instructions on how to keep themselves safe and report allegations. Residents felt like the information they received was helpful, but did not feel as if PREA was something they had to worry about at MonDay. All residents had some level of understanding and stated that should they need to report; they have the information necessary to do so.

Review:
Policy 3.9.3
Resident intake packet
Resident handbook
PREA posters
PREA reporting phone numbers
Resident files
Interview with residents
Interview with Intake RL
Interview with PREA Compliance Specialist

Standard 115.234: Specialized training: Investigations

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

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

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)
☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative
The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Agency policy 3.9.3 requires all administrative investigators to receive specialized training. The agency has six investigators as well as the PREA Coordinator who received in-person training from the Moss Group. The training provided includes:

- techniques for interviewing sexual abuse victims
- proper use of Miranda and Garity warnings
- evidence collection in a confinement setting
- required evidence to substantiate a case for administrative action or criminal referral

The agency retains completion of training certificates as proof of training.

The auditor was able to review the curriculum and training material provided by the Moss Group. The training was appropriate to the requirements of this standard.

During the onsite visit, the auditor was able to speak with five of the six administrative investigators. The administrative investigators were able to discuss the training they received on trauma informed care, evidence collection as it relates to administrative investigations in a confinement setting, proper documentation, and how to determine an appropriate finding to an investigation. The investigators report that should an investigation indicate criminal behavior, they will immediately stop the investigation and contact the local legal authority.

The administrative investigators understand the rules under the Garity laws; however, the investigators would not question an employee if a crime has been committed. All administrative investigations would resume after a criminal investigation or with permission from the local legal authority.

Review:
Policy 3.9.3
Training curriculum and material
Training certificates
Administrative investigator interviews
**Standard 115.235: Specialized training: Medical and mental health care**

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

**115.235 (a)**

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

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

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

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

**115.235 (b)**

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

**115.235 (c)**

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 3.9.3 requires all full and part-time medical and mental health care practitioners who work regularly at the facility to have been trained in:

- How to detect and assess signs of sexual abuse and sexual harassment
- How to preserve physical evidence of sexual abuse
- How to respond effectively and professionally to victims of sexual abuse and sexual harassment
- How and to whom to report allegations or suspicions of sexual abuse and sexual harassment

MonDay medical and mental health staff also receive the training mandated under standard 115.231.

The facility does have onsite medical practitioners; however, these practitioners would not complete a forensic medical exam. Should a resident be a victim of sexual abuse or sexual harassment, all residents would be seen by a SANE at Miami Valley Hospital.
The Clinical Manager at the facility states she conducts diagnostic assessments and she or a member of the clinical staff can meet with residents to conduct one-on-one sessions. She states that all clinical staff that perform any type of mental health service has received the specialized training provided by the PREA Resource Center website. All clinicians have also completed annual PREA employee training through the Relias online training system.

The auditor received course completion records for all training requirements for medical and mental health employees.

Review:
Policy 3.9.3
Interview with Clinical Manager
Course completion records

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**SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS**

**Standard 115.241: Screening for risk of victimization and abusiveness**

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

**115.241 (a)**

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

**115.241 (b)**

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

**115.241 (c)**

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

**115.241 (d)**
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident’s criminal history is exclusively nonviolent? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener’s perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident’s own perception of vulnerability? ☒ Yes ☐ No

115.241 (e)

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

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

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

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

115.241 (g)

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does
Policy 3.9.4 states that all residents will be assessed for risk of victimization or abusiveness within 72-hours of arrival at the facility. One of the facility clinicians will administer the screening instrument and considers the following:

1. Whether the resident has a mental, physical, or developmental disability
2. The age of the resident
3. The physical build of the resident
4. Whether the resident has a prior conviction for sex offenses against an adult or child
5. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, gender non-conforming, or intersex
6. Whether resident has previously experienced sexual victimization
7. The residents own perception of vulnerability
8. Prior acts of sexual abuse, prior convictions for violent offenses
9. Whether the resident has previously been incarcerated

The policy does not allow for residents to be disciplined for refusing to answer or not disclosing complete information to questions 1, 4, 6, or 7. The staff member is required to mark those responses as “refused to answer.”

The auditor was given a copy of the risk assessment instrument. The assessment gives definitions of terms used in the assessment, required assessment questions, and classification status. The form indicates that if a resident is identified as a possible victim or predator, a facility safety plan must be completed.

The auditor conducted an interview with the four clinicians and the Clinical Manager during the onsite visit. The clinicians reviewed their process for conducting risk assessments. Each clinician states that before they conduct the assessment they will review any available documentation about the resident. During the assessment the clinician will review what PREA is, go over words and terms that the clinician will be using during the assessment, assure the resident that the information is confidential, and explain that they do not have to answer personal questions. The clinicians state they will question the resident if any discrepancies arise between reported information and information found in collateral documents. Should the resident be identified as a possible victim or perpetrator, the clinician will consult with the Clinical Manager and the PREA Coordinator for concerns with housing, programs, work, and education accommodations. The clinician will also develop a safety plan.
The clinicians also complete the 30-day review. Policy 3.9.4 says within 30-days of the resident’s arrival at MonDay, the clinician will review the need to reassess the resident’s risk of victimization or abusiveness. The resident can also receive a reassessment when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness.

The auditor reviewed the review form, which is attached to the initial assessment form. Should there be a need identified during the review, a reassessment will be conducted. The clinicians state that they explain to the residents that the reassessment is just to ensure that the resident does not have any concerns about their safety and to confirm the information reported at intake is correct. The information on the assessments are kept in the resident’s confidential file. Staff only have access to the resident’s safety plan and not the information on the form.

The auditor interviewed the Clinical Manager and the Assistant Clinical Manager, both who perform quality assurance checks on the initial and reassessments. The Clinical Manager states that she is ensuring that the information on the form matches or is consistent with documented information. The Clinical Manager or Assistant Clinical Manager will sign verification of review on the assessment/review form.

The auditor interviewed twenty residents during the onsite visit. The residents were questioned on the risk assessment and reassessment. They state that they understand the need for the assessment and answered as honestly as possible. All residents reported feeling safe in the facility.

The auditor also reviewed ten resident files during the onsite visit. Each file contained the resident’s completed risk assessment, review, and if necessary a reassessment.

Review:
Policy 3.9.4
Risk assessments (initial and reassessments)
Resident files
Interview with Clinicians
Interview with Clinical Manager
Interview with Assistant Clinical Manager
Interview with residents
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 judgment.) ☒ 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 judgment.) ☒ 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 judgment.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s
Policy 3.9.4 states that the information from the risk screening will be used to ensure areas as housing, bed, work, education, and program assignments are made with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. The facility will make individualized determinations about how to ensure the safety of each resident depending on the circumstances, need, risk, and other variables.

The Clinical Manager states that any resident that is identified as at risk for victimization or abusiveness will receive a Facility Safety Plan. This plan documents the facility’s efforts to keep separate residents that are vulnerable from those who are abusive. The Clinical Manager and Assistant Clinical Manager will assist with developing a facility safety plan and communicating that plan with the necessary staff members.

The PREA Compliance Specialist states that there are no specific rooms identified for residents that are classified as potential victims or abusers; however, they will place these residents in beds where cameras have a clear view or in small rooms with other residents that do not have a potential abuser classification.

The Clinical Manager states the residents can have underlying issues related to their classification addressed if it related to issues identified on the resident risk/needs assessment.

Staff is trained on how to recognize factors that may increase a resident’s likelihood of being sexually victimized, possible warning signs that might indicate a resident has been sexually victimized, and increase staff surveillance, which includes conducting frequent and random area checks and maintaining an open line of communication with residents.

Policy 3.9.4 states that in deciding whether to assign a transgender or intersex resident to the male or female unit, and in making other programming assignments, MonDay considers each on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether the placement would present management or security problems. The facility is also required to consider a transgender or intersex resident’s own view with respect to his or her own safety. The policy does not allow the facility to house a lesbian, gay, bisexual, transgender, or intersex resident in dedicated facilities, units, or wings solely on the basis of such identification or status, unless the placement...
has been established with a consent decree, legal settlement, or legal judgement for the purpose of protecting such residents.

The PREA Coordinator reports that once the transgender assessment is completed, the facility will forward the results of the safety plan to staff responsible for ensuring the safety of the resident. She reports that the resident’s preferences will not be the sole determining factor for placement and handling but will be given serious consideration, along with the safety, security, and staffing of the facility.

The facility is currently housing a transgender resident. The PREA Coordinator reports that the agency consulted with the Bureau of Community Sanction’s Community Confinement PREA liaison on unit placement based on the information provided to the facility prior to placement. The Coordinator also spoke with the resident and considered the resident’s concerns related to safety.

The Clinical Manager reports that the facility will consider the following when addressing safety, security, and manageability of housing a transgender/intersex resident:

- Past incarcerations
- Mental health status
- Safety evaluation
- Resident concerns

The auditor spoke with the resident during the onsite visit. The resident reports that upon arrival she met with facility leadership and was able to voice concerns and unit placement preference. The resident states that the staff check in to ensure that no harassment or bullying is taking place. The resident does report some issues related to other residents but is satisfied with the response from the facility staff.

Review:
Policy 3.9.4
Facility safety plan
Interview with Clinical Manager
Interview with PREA Coordinator
Interview with PREA Compliance Specialist
Interview with transgender resident
Standard 115.251: Resident reporting

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

115.251 (a)

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

115.251 (b)

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

115.251 (c)

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

115.251 (d)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)
Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Policy 3.9.5 requires the facility to inform residents at intake, during orientation, in the Resident Handbook, and via posters that there are multiple ways for them to report sexual abuse, sexual harassment, retaliation by other resident or staff, and staff neglect or violation of responsibilities that may have contributed to such incidents. The reporting methods available include verbally, in writing, anonymously, and third party.

Residents are informed that they can report abuse or harassment to an outside agency by using the resident phones and dialing *9732#, which is toll-free. The outside agency is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to MonDay officials, allowing the resident to remain anonymous. The residents can use the phone in the dayroom to make anonymous calls. The residents also have access to digital mail in the dayroom. When accessing the kiosk, residents are able to click a PREA button and information on how to report will pop-up.

During the onsite visit, the auditor was able to use the resident phones to contact the outside reporting agency using the telephone number listed, as well as use the digital mail kiosk. Using both the auditor was able to follow the process a resident would use to report an allegation.

During the tour, the auditor noticed several postings in conspicuous places that listed reporting information for local, state, and national organizations. The information includes the name, phone number, and address for all organizations listed.

During the onsite visit, the auditor interviewed a total of twenty residents. The residents were asked questions in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook Guide for Effective Strategies for Interviewing Staff and Residents. This includes questions on ways a resident can report, private and anonymous reporting, and how residents received this information. Residents discussed the information they received during intake, orientation group, and house meetings. Residents understood their ability to report to any staff member and could make mention
of a staff member they felt comfortable reporting allegations. All residents stated they received a handbook during intake and that reporting options and phone numbers were listed in the handbook.

The auditor spoke with a resident who felt like he was being picked on due to his LGBTI status. He states that he was able to reach out to his clinician and discuss what was happening. The resident states that the staff member took his concerns seriously and addressed them appropriately. A few other residents also spoke about the response from staff to this incident. It has confirmed their belief that the staff members will respond appropriately to incidents of sexual abuse and harassment.

The auditor also spoke with other residents who are on TAP (Time Away from Peers) orders due to alleged harassing behavior. The incidents are not PREA but still considered harassment. The resident states that once she informed staff of the harassing behavior, the staff responded immediately to ensure her safety.

The auditor interviewed both targeted and random staff members and inquired about reporting options and obligations. All staff reported that all information they received concerning an incident or report of sexual abuse or sexual harassment they are to immediately report to their supervisor and document on a PREA Sexual Abuse/Harassment Report Form prior to the end of their shift. The staff report that they have been informed to make private reports directly to the PREA Coordinator or Director. The PREA Book located in every housing unit has the names and telephone numbers (work and home) listed.

Review:
Policy 3.9.5
PREA Sexual Abuse and Sexual Harassment Report Form
Agency website
Digital mail
Reporting hotline numbers
Interview with Administrative investigators
Interview with staff
Interview with residents

**Standard 115.252: Exhaustion of administrative remedies**

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

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

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

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

115.252 (f)

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

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

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

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

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

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

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

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

Policy 3.9.5 states that MonDay does not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. The facility does not require a resident to use any informal grievance process, such as submitting a Complain Form, or otherwise attempt to resolve with staff, an alleged incident of sexual abuse.

MonDay, per policy, will 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. The computation of the 90-days does not include time consumed by residents in preparing any administrative appeal. The facility can claim a 70-day extension of time to respond if the normal time period is insufficient to make an appropriate decision. The facility will notify the resident in writing of any such extension and provide a date by which a decision will be made.

The policy allows for third parties to assist residents in filing request for administrative remedies relating to allegations of sexual abuse, and allows third parties to file on a resident’s behalf. Should a third party submit such a filing, the facility will require the resident to agree to have the request filed on his/her behalf as a condition. The resident will then be required to personally pursue any subsequent steps in the administrative remedy process. If the resident declines, the resident’s decision will be documented.

Should a resident file an emergency grievance alleging the resident is subject to a substantial risk of imminent sexual abuse, the staff member receiving the grievance will:
• Immediately notify his/her supervisor and manager
• Supervisor or manager will immediately contact the Director and PREA Coordinator
• Immediate corrective action will be taken
• Initial response will be given within 48-hours
• Final decision will be made within 5 calendar days
• The initial and final decision will be documented. The reasoning for the determination will be noted as well as any action taken in response to the emergency grievance

The PREA Coordinator reports that the facility has not had a report of sexual abuse or sexual harassment processed through the grievance system, nor have they had an emergency grievance alleging imminent sexual abuse. She reports that the facilities first priority is keeping resident’s safe. She would immediately separate an alleged victim from an alleged abuser as soon as an allegation is made. The type of separation would depend upon the severity of the allegation and whether the allegation alleged a staff or resident abuser.

During the onsite visit, the auditor interviewed twenty residents. Most of the residents stated that they have never filed a grievance during their stay. There were two residents interviewed that stated that they have filed a grievance but it did not allege sexual abuse or harassment. The residents state that they received a response within a day or two from their initial filing and were satisfied with the process.

Review:
Policy 3.9.5
Interview with PREA Coordinator
Interview with residents

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Monday policy 3.9.5 requires each facility to provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers of local, state, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations, in as confidential manner as possible.
The facility informs residents that if they use the resident phone system, it is subject to monitoring and that reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The residents are informed that by request, they may use a facility phone that is not monitored in the most confidential way as possible.

The facility has a Memorandum of Understanding (MOU) with the Victim Witness Division of the Montgomery County Prosecutor’s Office to provide the residents with confidential emotional support services related to sexual abuse. The MOU lists the Division’s telephone number and address that residents can use.

After the onsite visit, the auditor contacted the Director of the Montgomery County Victim/Witness Division via email and requested confirmation of services listed on the MOU and that the services are provided free of charge. The Director returned the email and confirmed the 24-hour hotline number and address and that the advocates at the division will provide emotional supportive services to all residents at MonDay.

Policy 3.9.5 requires 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. The residents are informed that they have the right to privacy while making a report of sexual abuse to outside agencies; however, due to state and federal mandatory reporting laws, the agency may be required to report allegation.

During the onsite visit, the auditor was able to view posting in resident areas the listed the name, address, and telephone number of the Montgomery County Victim/Witness Division. The auditor also reviewed this information inside resident handbooks.

*The national rape crisis advocacy organization, RAINN, does not keep record of calls into the center. All calls are anonymous and callers are forwarded to their local rape crisis agency.

Review:
Policy 3.9.5
PREA Postings
Montgomery County Victim/Witness Division MOU
Resident Handbook
Email with Division Director
Staff interviews
Resident interviews
Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Agency policy 3.9.5 requires the posting of the various methods third-parties can make reports of sexual abuse and sexual harassment. The auditor reviewed the agency website (https://www.mcohio.org/government/county_agencies/monday/prea.php) and was able to see the posted information on how to report an allegation. The information posted includes:

- MonDay PREA Coordinator phone number (937-496-3008)
- Email to info@mondaycbcf.com

The auditor tested the reporting method posted and received a reply from an administrative investigator on the same day of the auditor’s initial email.
The residents are also informed how to make a third party report or inform their family on how to make a third party report on their behalf. This information for residents and visitors is provided:

- To each resident at intake
- In the resident handbook
- On the MonDay website
- On posters in public areas of the facility
- In the visitor orientation training

The auditor also called the outside agency hotline number. A representative from the outside agency (Ohio Department of Rehabilitation and Corrections Bureau of Community Sanctions) returned the auditor’s phone call and confirmed that they are a reporting agency and would report all allegations to the PREA Coordinator.

The facility has posted in conspicuous places, including areas where visitors would frequent, notices on how a person can make a third-party report of sexual abuse or sexual harassment on behalf of a resident. The notices include toll-free hotline numbers and the email address that is listed on the agency website.

The auditor reviewed all investigations for the past twelve months. No allegation was reported by a third party.

Review:
Policy 3.9.5
Agency website
Investigation reports
PREA notices
PREA hotline number

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)
Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

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

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

115.261 (b)

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

115.261 (c)

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

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

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)
Instructions for Overall Compliance Determination Narrative

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

Policy 3.9.6 states that all staff are required to immediately report:

- Any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment (whether it occurred on-site or off-site)
- Retaliation against residents or staff who report such an incident
- Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation

Policy requires staff to not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Staff are trained on their duty to report all allegations, including third-party and anonymous allegations, to a supervisor, manager, Assistant Director or Director immediately. Staff are required to sign an acknowledgement of their understanding of how to fulfill their responsibilities of preventing, detecting, responding, and reporting incidents of sexual abuse, sexual harassment, and retaliation.

A review of the PREA Book located in all housing units, staff are provides instructions to staff on how to report resident sexual abuse or harassment. The book provides phone numbers for the PREA Coordinator, PREA Compliance Specialist, investigators and required reporting form.

The auditor reviewed ten employee files during the onsite visit. It was noted by the auditor that each staff file contained a signed acknowledgment of receiving the following information:

- Client confidentiality
- Code of ethics
- Employee discipline
- Clients rights and grievance procedure
- Ethics and accountability
- PREA annual acknowledgement
The auditor interviewed programming, security, and administrative staff during the onsite visit. The staff were interviewed on agency reporting protocols and expected practice. All staff were capable of listing the reporting options available to residents, staff, and outside sources. The staff were aware that residents were allowed to verbally report and report anonymously. The staff state that during onboarding and annual training, they receive information on their responsibility to report.

The auditor spoke to several members of the clinical staff who report their responsibility to inform residents of their duty to report and the limitations of confidentiality at the initiation of services.

The auditor spoke with several staff members who have reported allegations in the past. The staff member report being able to go to their supervisors or directly to the PREA Coordinator to report the information that they received from residents. One staff member made a report based on suspicion. The staff members know the location of the “PREA Book” and how to complete the form.

Policy 3.9.6 states that if the alleged victim is under the age of eighteen (MonDay does not house residents that are under the age of eighteen) or considered a vulnerable adult under a State or local vulnerable persons statute, MonDay will report the allegation to the appropriate State or local services agency under applicable mandatory reporting laws.

The PREA Compliance Specialist states that the facility has not has an allegation that involves a resident under the age of eighteen or a vulnerable adult.

Review:
Policy 3.9.6
Employee files
PREA book
Interview with staff
Interview with PREA Coordinator
Interview with PREA Compliance Specialist

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**Standard 115.262: Agency protection duties**

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

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Agency policy 3.9.6 states that as soon as the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, the Director or designee will take immediate action to protect the resident. An Imminent Risk of Sexual Victimization Form will be completed and forwarded to the PREA Coordinator.

The male building has three housing units and the female building has two housing units. The agency is able to separate resident alleged victims from alleged resident abusers. The PREA Coordinator and Director report that it is policy to place a staff member on administrative leave during an investigation into sexual abuse. Staff members can be moved to work in a different housing unit or building for allegations of sexual harassment depending upon the severity. The facility will always err on the side of resident safety.

The auditor reviewed the allegations reported during the past twelve months. One allegation was reported after the resident was no longer housed at the facility; therefore, no protection measures were deployed. There was an unfounded sexual harassment allegation against a staff member. The staff member was sent to the other building to work during the investigation. The auditor was able to interview the staff member during the onsite visit. The staff member states that while the allegation was unfounded, there was some retaining as a result. The staff member continues to work in the other building.

The Clinical Manager states that whenever residents are having issues with another residents, they will be put on a TAP (Time Away from Peers) order. This order alerts
staff that the two residents are not to be around each other and to increase the monitoring of their actions. This also helps in protecting resident victims from resident retaliation.

During the onsite visit, the auditor was able to speak to two residents that are currently on TAP orders. The residents state that because they were unable to have respectful communication with each other they must stay away from each other until they have a meeting. The residents report that if they are caught talking or being around the other resident is can result in a sanction. Only a supervisor can remove residents from a TAP order.

No resident has reported to the facility that they were in fear of imminent sexual abuse.

Review:
Policy 3.9.6
Investigation reports
Interview with administrative investigators
Interview with Director
Interview with residents
Interview with Clinical Manager
Interview with staff member

### Standard 115.263: Reporting to other confinement facilities

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

**115.263 (a)**

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

**115.263 (b)**

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

**115.263 (c)**

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

**115.263 (d)**
Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

Agency policy 3.9.6 states that upon receiving an allegation that a resident was sexually abused while confined at another confinement facility, the Director or designee shall notify in the head of that facility or appropriate central office of the agency where the abuse occurred. The policy mandates that the notification shall be provided as soon as possible, but no later than 72-hours after receiving the allegation.

Policy 3.9.6 also mandates allegations received from other facilities and agencies must be reported to the Director or PREA Coordinator as soon as possible. The Director will ensure that the allegation is investigated in accordance with the PREA standards.

During the onsite visit, the auditor interviewed agency investigators. The investigators reviewed all allegations from the past twelve months with the auditor. There were no investigations that were conducted based on an allegation reported from another confinement facility.

During an interview with the PREA Coordinator, she reports that the facility has reported five allegations to other confinement facilities. The auditor was able to view the emails sent to the various other confinement facilities regarding the allegations. The emails were sent within the required time limit.

Policy 3.9.6
Interview with PREA Coordinator
### Standard 115.264: Staff first responder duties

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

#### 115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?  
  ☒ Yes  ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?  
  ☒ Yes  ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?  
  ☒ Yes  ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?  
  ☒ Yes  ☐ No

#### 115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?  
  ☒ Yes  ☐ No

### Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** *(Substantially exceeds requirement of standards)*
- ☒ **Meets Standard** *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ **Does Not Meet Standard** *(Requires Corrective Action)*

### Instructions for Overall Compliance Determination Narrative

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does...*
MonDay policy 3.9.6 outlines first responder duties for any allegation of sexual abuse. The policy instructs first responders to:

- Separate the alleged victim and abuser
- If there is a crime scene, preserve and protect it by clearing all residents and unnecessary staff from the area until law enforcement can assume responsibility of the crime scene
- If the abuse occurred within a time period that still allows for the collection of physical evidence (usually 96 hours), request the alleged victim not take any action 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, do not allow the alleged abuser to take any action that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.

If the first staff responder is not an Operations staff member, the responder will request that the alleged victim not take any actions that could destroy physical evidence and then notify Operations staff.

In reviewing the First Responder Checklist, the first responder is also required to:

- Contact medical services- Miami Valley Hospital and ask for a SANE to be on duty
- Notify Supervisor and Assistant Director (Assistant Director will notify investigator)
- Notify PREA Coordinator
- Notify Clinical Manager or Assistant Clinical Manager to contact an emotional support person or victim advocate

The “PREA Book” has the First Responder Checklist form along with a PREA Contact information and telephone numbers. The numbers include those for the PREA Coordinator, PREA Compliance Specialist, MonDay Emotional Support staff, administrative investigators, Miami Valley Hospital Emergency Room, and victim...
support. All staff are trained on first responder duties (security and non-security staff). The First Responder Checklist divides the responsibilities for security first responders and non-security first responders. The training is giving during onboarding training, and again during annual training. The auditor was given a copy of the training curriculum and sign-in sheets.

The staff state that other than having to separate the alleged abuser and victim, they have not had to employ the first responder step duties. All staff report feeling comfortable deploying the steps should an incident of sexual abuse take place.

The facility has not had an allegation of sexual abuse where the facility would have to deploy all first responder steps.

Review
Policy 3.9.6
Interview with staff
Investigation reports
First Responder Checklist
PREA contact information and telephone numbers

Standard 115.265: Coordinated response

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

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative
Policy 3.9.6 describes MonDay’s Coordinated Response plan to coordinate actions taken to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and management.

The coordinated response plan is contained in the PREA Book that is in each housing unit. During onboarding and monthly back to basic training, staff learn the coordinated response plan and the location of the posted plan.

The Coordinated Response Plan:

- Enact first-responder duties
- Contact supervisor, if supervisor is not available, contact Assistant Director or designee
- Secure the crime scene. Take photographs as needed
- Complete a PREA Sexual Abuse/Harassment Report Form

Supervisor responsibilities after receiving a report of sexual abuse are to:

- Immediately notify manager and Assistant Director or designee
- Call local law enforcement, if appropriate
- Ensure that the alleged perpetration and victim are separated (separation should not be a form of punishment)
- If the alleged perpetration is an employee, volunteer, or contractor, the supervisor should determine the appropriate method of separation and then direct the individual to remain in the designated area and to not use the phone.
- Ensure the individual is supervised until the arrival of local law enforcement
- If medical staff are on duty, notify them of the allegation (MonDay medical staff will not collect forensic evidence or perform a forensic exam, but may be needed for immediate medical treatment
- Call the Miami Valley Emergency Room, notifying them of the need for a sexual abuse forensic exam, and ask them to contact a Sexual Assault Nurse Examiner to meet the resident at the hospital
- Explain to the victim the necessity of a physical exam to assess medical needs, provide any necessary treatment, and to ensure preservation of evidence
• As the victim if he/she would like the Victim Witness Division contacted to provide support services
• Notify the Clinical Manager/Assistant Clinical Manager
• Clinical Manager/Assistant Clinical Manager will contact victim support person to provide in-house services and complete a Victim Support Person Activity Report
• Transport the victim to Miami Valley Emergency Room
• Complete a Sexual Abuse/Harassment Report Form as soon as is practical and forward it to the PREA Coordinator

The auditor was viewed the posted plan during the onsite visit.

Review:
Policy 3.9.6
PREA Book
Coordinated Response Plan

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

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

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency’s behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.266 (b)

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

☐ Does Not Meet Standard *(Requires Corrective Action)*
Instructions for Overall Compliance Determination Narrative

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

N/A: The Human Resource Director reported during her interview with the auditor that the agency does not have a union and does not enter into contracts with its employees. The agency is an “At Will” employer. Staff members sign an “At Will” employer acknowledgement during onboarding.

Review:
Interview with Human Resource Director

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct
and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☒ Exceeds Standard

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

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

**Instructions for Overall Compliance Determination Narrative**

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

Policy 3.9.6 states the facility is 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. The Director will assign the Assistant Director or PREA Coordinator to monitor retaliation.

The facility has multiple ways of protecting against retaliation which include:

- Reassigning the resident’s pod and bed location
- Termination of victim or abuser
- Removal of alleged staff or resident abusers from contact with victim
- Providing emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

The auditor was able to interview the Assistant Director during the onsite visit. He states that he or the PREA Coordinator would be responsible for ensuring that residents and staff members are not retaliated against. He states that for 90-days the facility will monitor the resident, which includes reviewing incident reports, rule violations, housing or program changes, negative performance reviews, and staff reassignments. Should the resident or staff member be facing retaliation, the facility will act promptly to remedy any such retaliation.

The auditor was able to review the agency’s Retaliation Monitoring Form. The form monitors changes that may suggest possible retaliation by residents or staff. Should there be indicators, the staff member will document the incidents. The Clinical department will conduct periodic status checks with resident victims.
Agency policy 3.9.6 states that the agency’s obligation to monitor shall terminate if the allegation is determined to be unfounded. The Assistant Director reports that if necessary, the facility will continue to monitor past the 90-day obligation.

The Program Administrator reports that no resident has reported an incident of retaliation.

Review:
Policy 3.9.6
Retaliation Monitoring form
Interview with Assistant Director

### INVESTIGATIONS

**Standard 115.271: Criminal and administrative agency investigations**

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

**115.271 (a)**

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

**115.271 (b)**

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

**115.271 (c)**

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
• Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

• When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.271 (e)

• Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff? ☒ Yes ☐ No

• Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.271 (f)

• Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

• Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.271 (g)

• Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.271 (h)

• Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.271 (i)

• Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.271 (j)
Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
☒ Yes ☐ No

115.271 (k)

Auditor is not required to audit this provision.

115.271 (l)

When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☒ Exceeds Standard (Substantially exceeds requirement of standards)
☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Policy 3.9.7 requires the facility to conduct investigations into allegations of sexual harassment and sexual abuse. The facility will investigate allegations of sexual abuse if there is not initially enough evident to call in local law enforcement. Investigations will be prompt, thorough, and objective for all allegations, including third-party and anonymous reports. Only staff who have had special training in sexual abuse investigations will be allowed to conduct investigations on allegations of sexual abuse or sexual harassment. If the alleged abuser is a staff member, the administrative investigation will be from a different department than the staff being investigated.
The policy requires the facility to document the investigation in a written report that is retain by the PREA Coordinator for as long as the alleged abuser is a MonDay resident, or is employed by MonDay, plus five years. Policy requires the administrative investigator to:

- Gather and preserve direct and circumstantial evidence to include DVR recordings; interview alleged victim, alleged abuser, and witnesses; and review prior complaints and reports involving the suspected perpetrator
- Not base credibility of an alleged victim suspect, or witness on the person’s status as a resident or staff
- Not require anyone to submit to a polygraph examination or other truth-telling devise

Policy states that when the quality of evidence appears to support the allegation of sexual abuse or cannot be substantiated, but is not determined to be unfounded, the facility must contact local law enforcement to conduct a criminal investigation. Administrative investigators cannot conduct compelled interviews so as to not be an obstacle for any criminal prosecution.

The PREA Coordinator reports that all allegations that appear to be criminal will be referred to Dayton Police Department or Montgomery County Sheriff’s Department. Once a referral has been made, the PREA Coordinator or the Director will request the agency responsible keep the facility informed about the progress of the investigation.

The auditor reviewed the training curriculum and certificates for completion for all administrative investigators. The training was conducted by the Moss Group and included techniques for interviewing sexual abuse victims, proper use of Miranda and Garity warnings, sexual abuse evidence collection in a confinement setting, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

The administrative investigators report per policy will include a description of the physical and testimonial evidence, the reason behind credibility assessments, and investigative facts and findings. The auditor was able to review an investigative report. The report includes:

- Name of victim
- Name of alleged abuser
- Type of allegation
• Name of investigator
• Date and time of incident
• Location of incident
• Alleged abuse status (resident or staff)
• Witnesses
• Statements
• Video evidence
• Legal action
• Other physical evidence

A summary of the investigations can be found in standard 115.222.

The PREA Coordinator and PREA Compliance Specialist, both trained investigators, discussed the process for conducting an investigation, reasoning for allegation determination, and making referrals for a criminal investigation. They report that all administrative investigators have received their training from the Moss Group and understand how to conduct trauma informed care interviews; collect circumstantial and physical evidence; use collateral information to make credibility assessments; and review past reports and behavioral observations.

The investigators state because of Garity laws they are not to question a suspected abuser during a criminal investigation. The administrative investigation would only begin at the conclusion of the criminal investigation or with the permission of the legal authority.

The investigators report that the absence of the alleged abuser or victim is not a basis for terminating an investigation.

Review:
Policy 3.9.7
Investigation reports
Interview with PREA Coordinator
Interview with PREA Compliance Specialist
Administrative investigator training certificates

**Standard 115.272: Evidentiary standard for administrative investigations**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**
115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Agency policy 3.9.7 states that the agency imposes a standard of preponderance of evidence or 51% to substantiate an allegation of sexual abuse or sexual harassment.

The auditor interviewed the facility’s administrative investigators on the standard of proof used when making allegation determinations. All report using 51% as the measure to substantiate an allegation. The facility Director must review and sign off on all investigation reports. The Director has the final say in allegation determination.

The auditor reviewed the allegations from the past twelve months to verify the standard of proof used. The allegations were determined with that standard.

Review:
Policy 3.9.7
Investigation reports
Interview with PREA administrative investigators
Interview with Director

Standard 115.273: Reporting to residents
All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

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

115.273 (b)

- If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in the agency’s facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

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

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Policy 3.9.7 states that when the investigation is complete, MonDay will inform a resident who has alleged sexual abuse as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. If MonDay did not conduct the investigation, the PREA Coordinator will request the relevant information from the investigative agency in order to inform the resident.

The facility will also notify the resident whenever:

- The employee is no longer working at the resident’s assigned facility
- The employee is no longer employed by the agency
- The agency learns the employee has been convicted on a charge related to sexual abuse within the agency
- The agency learns the alleged resident abuser has been indicted on a charge related to sexual abuse within the facility
- The agency learns that the alleged resident abuser has been convicted on a charge related to sexual abuse in the facility
All such notifications or attempted notifications are documented. The obligation to make such report under this standard shall terminate if the resident is released from the agency prior to an investigation determination.

The facility had one allegation of staff-to-resident sexual abuse during the past twelve months. The staff-to-resident allegation was administratively investigated and determined to be substantiated. The facility had another staff-to-resident allegation that originated outside of the facility by the Dayton Police Department. The department has not reported to the facility the determination of that allegation. The resident is no longer at the facility. The facility was allowed to conduct an administrative allegation and determined that the allegation was unfounded. No notification can be sent at this time.

The auditor received a copy of the notification form and the notification included information included all required information.

Review:
Policy 3.9.7
Interview with administrative investigators

**DISCIPLINE**

**Standard 115.276: Disciplinary sanctions for staff**

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

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No
115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to:
  - Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
  
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to:
  - Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy 3.9.8 states that staff are subject to disciplinary sanctions up to and including termination for violating MonDay’s sexual abuse or sexual harassment policies. Staff found to have engaged in sexual abuse will be terminated from employment at MonDay.

Disciplinary sanctions for violations of MonDay policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed on other staff with similar histories.

MonDay will report all terminations for violations of MonDay’s sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

The agency outlines its progressive disciplinary plan in its employee handbook. A review of the handbook states that any staff member found to have engaged in sexual abuse will be terminated. Termination or resignation by a staff member who otherwise
would have been terminated for violations of the Client Sexual Abuse and Sexual Harassment Prevention, will be reported to law enforcement agencies and any relevant licensing bodies. The handbook also states that employees who have knowledge of resident victimization and do not report it will be terminated.

The auditor interviewed the Director, PREA Coordinator, and Human Resource Director during the onsite visit. The administrators report that it is agency practice to place a staff member on administrative leave or, depending on the severity of the allegation, place the staff member on a different unit or building during the course of an investigation. The Director states the agency enforces their strict zero tolerance policies by terminating employees found to be in violation of the policy. He states that it is important that the facility maintains a culture of zero tolerance, and the resident believe that the facility will respond appropriately to any allegation.

The auditor reviewed ten employee files. All files contained acknowledgements of receiving the employee handbook and the agency’s zero tolerance policy. Employees who have been disciplined by the agency had a Notice of Reprimand. The documentation listed the disciplinary charge, disciplinary action, and performance improvement plan.

The facility had three allegations that involved staff members. One was substantiated and two were unfounded. The staff member involved in the substantiated allegation was terminated for violations of the zero tolerance policy. One of the staff members involved in an unfounded allegation was moved to a different unit during the investigation. This staff member was disciplined based on violations of MonDay policy and not sexual harassment. The discipline was consistent with agency policy. The other staff member in an unfounded allegation did not need to be moved during the investigation due to the resident not being at the facility during the allegation or investigation.

During random and targeted staff interviews, all reported signing a zero tolerance acknowledgement annually and understanding that termination is the presumptive disciplinary action to violations of MonDay’s zero tolerance policy.

Review:
Policy 3.9.8
Zero tolerance acknowledgement
Employee Handbook
Investigation reports
Interview with Human Resource Director
Interview with Director  
Interview with PREA Coordinator  
Interview with staff

**Standard 115.277: Corrective action for contractors and volunteers**

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

**115.277 (a)**

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

**115.277 (b)**

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☐ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ Exceeds Standard *(Substantially exceeds requirement of standards)*  
☒ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*  
☐ Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

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Policy 3.9.8 restricts MonDay from engaging the services of any contractor, volunteer, or intern who commits sexual abuse, and will report such behavior to law enforcement agencies, unless the activity is clearly not criminal, and to any relevant licensing bodies.
The facility is required to take appropriate remedial measures, and will consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor, volunteer, or intern.

During the onsite visit, the auditor reviewed all allegations reported within the past twelve months. There have been no allegations against a contractor or volunteer.

The PREA Coordinator stated during her interview that the facility has not had any incident concerning the interactions between a contractor/volunteer and a resident.

Review:
Policy 3.9.8
Investigation reports
Interview with PREA Coordinator

**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
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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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MonDay policy 3.9.8 prohibits all sexual activity between residents. Residents will be subject to a formal disciplinary process following an allegation that the resident engaged in resident-on-resident sexual abuse. If the administrative and/or criminal investigation finds the resident guilty for resident-on-resident sexual abuse, the resident will be unsuccessfully terminated from the program.
In the resident handbook, residents are informed on behavior that could warrant a sanction. The handbook lists expected behavior and a code for daily living. These expectations include:

- Respectful language and interaction
- Respectful cultural, racial, gender, and/or sexual orientation differences
- Respectful physical boundaries

The handbook provides the residents with a sanctioning grid that represents the sanctions that will be applied to resident that fail to follow program expectations and the code for daily living. Possible violations that are related to the agency’s zero tolerance policy include:

- Communicating with residents of the opposite gender
- Making rude comments or gestures
- Sexual harassment
- Sexual activity

The auditor reviewed ten resident files during the onsite visit. The auditor was able to verify resident acknowledgement of receiving the resident handbook and agency zero tolerance policy.

For the purpose of disciplinary action, policy 3.9.8 does not allow a resident to be disciplined for making a sexual abuse allegation in good faith based on a reasonable belief that the alleged conduct occurred even if an investigation does not establish evidence sufficient to substantiate the allegation. The policy also states that residents may be disciplined for sexual contact with staff only upon finding that the staff member did not consent to such contact.

The PREA educator states that during orientation group, the residents get a clear understanding of what is a good faith report of sexual abuse or sexual harassment versus a bad faith or false/misleading report. The residents also informed that PREA violations can include staff abusers and there is no such thing as consent when it involves relationships with staff, contractors, and volunteers.

The PREA Coordinator reports that the facility has disciplined a resident in the past for filing a patently false PREA allegation. The resident that was involved in a “consensual” relationship with a staff member was not disciplined for the relationship.
The PREA Coordinator reports that termination is the sanction for all resident found to have sexually abused another resident. All other substantiated allegations of sexual harassment will be disciplined according to the agency’s progressive discipline policy. The residents that have been involved in substantiated sexual harassment allegations of been disciplined according to agency policy.

The facility has not had a substantiated allegation of resident-to-resident sexual abuse during the past twelve months.

During resident interviews, all residents were aware of the facility’s zero tolerance policy, received a handbook during intake, participated in orientation group and understood the facility’s disciplinary policies. When questioned on the possible sanction for a violation of the policy, all residents stated that termination from the facility would be the consequence for a PREA violation.

Review:
Policy 3.9.8
Resident handbook
Interview with PREA Coordinator
Interview with residents
Investigation report
Resident files

## MEDICAL AND MENTAL CARE

### Standard 115.282: Access to emergency medical and mental health services

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

#### 115.282 (a)

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

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Policy 3.9.9 mandates 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 judgement.

The agency’s medical and mental health staff will maintain documentation, either in the resident’s medical chart or clinical progress note of any emergency medical treatment or crisis intervention that they provide which denotes:
• The timeliness of emergency medical treatment and/or crisis intervention services that were provided
• The appropriate response by non-medical staff in the event medical staff are not present at the time the incident is reported
• The provision of appropriate and timely information and services concerning contraception and sexual transmitted infection prophylaxis

The PREA Coordinator reports that residents who experience sexual victimization would be offered services by Miami Valley Hospital Emergency Room. The protocol by the hospital to treat victims of sexual assault include diagnostic testing based on patient need and will be identified by the Emergency Trauma Center attending physician and the SANE. The hospital currently follows the CDC *Sexually Transmitted Diseases Treatment Guidelines*. The guidelines include:

• Medications to treat sexually infectious diseases
• Options of pregnancy prevention
• Referrals for social services
• Follow up physician’s appointments
• Referrals for mental health assessments

The SANE will also contact the agency responsible for rape crisis services. If the resident request, the facility can provide a trained emotional support staff member.

The PREA Coordinator states that staff are trained on the agency’s Coordinated Response Plan which includes contacting medical and victim support services.

The Director of the Montgomery County Victim Witness Divisions reports that the following services will be offered to residents who request services include:

• 24-hour crisis line
• 24 hour response to area hospital emergency rooms
• Support and information to any victim
• Explanation of criminal justice process
• Advocacy and assistance during court proceedings

Policy 3.9.9 State that all services shall be 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.
The facility has not had an allegation during this audit cycle that required medical or mental health services.

Review:
Policy 3.9.9
Coordinated Response Plan
Miami Valley Hospital Emergency Department SANE Protocol/Policy
Email from Director of Montgomery County Victim Witness Division
Interview with PREA Coordinator

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

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

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.) ☒ Yes ☐ No ☐ NA

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

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

The facility offers community medical and mental health counseling services for residents who have been sexually abused in jail, lockup, or juvenile facility. Policy 3.9.9 states that the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and when necessary referrals for continued care following their release from MonDay.
MonDay Provides victims with medical and mental health services consistent with the community level of care. If the medical and mental health staff at MonDay are not able to provide the care needed, the facility will make arrangements for the resident to obtain the services off-site.

The Clinical Manager states that residents who are in need of mental health services can meet with a psychiatrist and meet with a clinician for one-on-one sessions. She states that should the resident have needs that cannot be addressed at the facility. The facility would make an appointment with a community provider and transporting the resident.

The facility has not received a report of a resident being sexual abused while in a jail, lockup, or juvenile facility prior to intake at this facility during this audit cycle.

The policy also states that should a pregnancy result from sexually abusive penetration while incarcerated, timely and comprehensive information about and timely access to all lawful pregnancy related medical services will be offered. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser(s) or cooperates with any investigation arising out of the incident.

The PREA Compliance Specialist states that the facility has not had a victim of sexual abuse that has needed medical or mental health services during this audit cycle.

Policy states that MonDay will 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.

The PREA Compliance Specialist states that the agency has not been notified of any known resident-to-resident abuser. This information would be collected at intake in documentation provided to the facility from the resident’s parent agency or a resident could self-report during risk assessments. Should the facility become aware that a resident has previously abused another resident, the Clinical Manager would meet with the resident to assess how to address any underlying issues.

Review:
Policy 3.9.9
Coordinated Response Plan
Interview with PREA Compliance Specialist
Interview with Clinical Manager
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 Specialist? ☒ Yes ☐ No
115.286 (e)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

MonDay policy 3.9.10 will 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. The sexual abuse incident review will occur within 30-days of the conclusion of the investigation unless there are extenuation circumstances. Any delay will be documented and the review scheduled as soon as possible. The team shall include managers, within put from supervisors, coordinators, investigators, and medical staff.

According to agency policy and as well as the PREA Coordinator, the team shall consider the following when reviewing the allegation and investigation:

- Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse
- Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility
- Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse
- Assess the adequacy to staffing levels in that area during different shifts
• Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff

The team will prepare a report of its findings, including but not limited to determinations made pursuant to the above items of this section, and any recommendations for improvement, and submit such report to the Director and PREA Coordinator.

The auditor interviewed Assistant Director, Operations Coordinator, Assistant Operations Manager, Clinical Manager, Director, PREA Coordinator, and PREA Compliance Specialist who all are either on the SART or are responsible for implementing recommendations from the SART. The members of the team that were interviewed state that they complete a Sexual Assault Response Team Checklist for every sexual abuse allegation that has been determined to be substantiated or unsubstantiated. The review will take place within 30-days of the completions of the investigation. The team may also meet to discuss any allegation that involves staff regardless of the investigation outcome or if the allegation was sexual harassment.

The auditor was able to review the SART Checklist. The checklist includes:

• A summary of the incident
• Victim care
• Receipt of medical, mental health, rape crisis, emotional support services
• Review of policies and procedures (confidentiality and duty to report)
• Prior report(s) against the perpetrator
• If prior report(s), agency response to incident(s)
• First responder
• Additional employee training recommended
• Timely response
• Notification of law enforcement
• If, notified, review police report
• Whereabouts of the victim
• Whereabouts of the abuser
• Physical vulnerabilities identified
• Media attention
• Risk screening
• Abuse motivated by race, ethnicity, gender identity, LGBTI/perceived, gang related, or other factor
• Inadequate staffing levels during shift
Deploy or augment monitoring technology

The team members state that once the review check list is complete, they will make recommendations on changes to policy and procedure; improvements to facility security; and any internal service not currently provided, which may improve resident safety from sexual victimization.

The recommendations are presented to the Director during a management meeting and discuss any recommendations. The Director reports that cultivating a zero tolerance culture is most important when deciding which recommendations to implement. He states that recommendations that are implemented will be reviewed monthly during the management meeting to ensure the recommendations are working as intended. If there is a recommendation that is not implemented, the team will document the reasons for not doing so.

The PREA Coordinator states that she is responsible for ensuring recommendations are implemented. She will review the progress of implementation during management meetings.

There was one allegation of sexual abuse that was reviewed by the SART during the past twelve months. The allegation was determined to be substantiated. The team reviewed all the required areas and determined did not make any recommendations. The team also reviewed an allegation that involved staff exposing himself while using the bathroom. The team determined that the incident was not PREA, but made the recommendation that staff not be allowed to use a resident bathroom.

Review:
Policy 3.9.10
Sexual Assault Response Team Checklist
Interview with PREA Coordinator
Interview with PREA Compliance Specialist
Interview with Director
Interview with Assistant Director
Interview with Clinical Manager
Interview with Operations Manager

**Standard 115.287: Data collection**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**
115.287 (a)  
- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

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

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does...*
Agency policy 3.9.10 requires the PREA Coordinator to collect accurate, uniform data for every allegation of sexual harassment and abuse using the MonDay Allegation Tracking Sheet, which is based on the information required by the Bureau of Justice Form SSV-2, Survey of Sexual Violence. The PREA Allegation Tracking Sheet includes allegations of sexual harassment, sexual abuse, and definitions.

The information on the form is aggregated and listed in the agency’s annual PREA report. The report is posted on the agency’s website, https://www.mcohio.org/PREA_Annual_Report_FY17.pdf. The auditor accessed the agency’s website and reviewed the 2018 annual report. The report contains the aggregated sexual abuse and sexual harassment allegation data and a comparison of data from the previous fiscal year.

The auditor reviewed the Allegation Tracking Sheet and verified that the agency is collecting the required information to complete the Bureau of Justice’s Survey of Sexual Violence form. The facility is also required to collect data for every allegation of sexual harassment and sexual abuse for the Bureau of Community Sanctions. The auditor reviewed that report as well. The information on that report is more than sufficient to complete the SSV-2 form.

The Coordinator reports that the Department of Justice has not made a request for this information.

Review:
Policy 3.9.10
Allegation Tracking Sheet
BCS Allegation Tracking Sheet
Agency website
Interview with PREA Coordinator

Standard 115.288: Data review for corrective action

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

115.288 (a)
 Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

 Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

 Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

 Does the agency’s annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse ☒ Yes ☐ No

115.288 (c)

 Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.288 (d)

 Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.
MonDay policy 3.9.10 states that the agency will use the information collected in standard 115.287 to assess and improve the effectiveness of the agency’s resident sexual abuse prevention, detection, and response policies, practices, and training which includes:

- Identifying problem areas
- Taking corrective action on an ongoing basis
- Preparing an annual report of its findings and corrective actions for each facility as well as the agency as a whole

The report will include a comparison of the current year’s data and corrective actions with those from prior years and will provide an assessment of MonDay’s progress in addressing sexual abuse. The auditor access the agency’s website and reviewed the annual report. The report includes statistical data from the current and previous year and the efforts the agency has taken in order to reduce the incidents of sexual abuse and sexual harassment. The facility contributes staff and training and resident education with the number of reported allegations. The facility states that it will continue its efforts to have staff maintain a continuous physical presence in the resident living areas and video monitoring in order to increase its efforts to prevent, detect, and respond to incidents of sexual abuse and sexual harassment.

The information in the report does not contain any identifying information that would need to be redacted in order to protect the safety of the residents, staff, or facility.

The information in the report has been reviewed and approved by the agency’s Director. The report is posted on the agency’s website at: https://www.mcohio.org/PREA_Annual_Report_FY17.pdf.

Review:
Policy 3.9.10
PREA annual report
Agency website

**Standard 115.289: Data storage, publication, and destruction**

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

115.289 (a)
Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

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

115.289 (c)

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

115.289 (d)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Agency policy 3.9.10 requires the agency collect data requested in standard 115.287 and that this information will be aggregated, and made available to the public through the agency’s website. The information posted to the agency’s website is required to have all personal identifying information removed. The facility is mandated by policy to securely retain the information collected and to retain the data collected for at least ten years after the initial collection unless Federal, State, or local law requires otherwise.
The auditor accessed the agency’s website, https://www.mcoho.org/PREA_Annual_Report_FY17.pdf, to ensure that the agency has posted its annual report. The annual reports are completed based on a fiscal year. The information in the report is collected by the agency’s PREA Compliance Specialist. The agency PREA Compliance Specialist aggregates the information and prepares the information for the annual report. The PREA Coordinator uses the information provided and develops the annual report which is reviewed and signed by the agency Director.

The PREA Coordinator reports that all information is only accessible to approved staff members and that she retains control of all information. The information is kept for ten-years from the time of collection.

The auditor did not view any information in the report that could jeopardize the safety and security of the facility, nor was there any personal identifying information contained in the report.

Review:
Policy 3.9.10
Agency website
PREA annual reports
Interview with PREA Coordinator
# AUDITING AND CORRECTIVE ACTION

## Standard 115.401: Frequency and scope of audits

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

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

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

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

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

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

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

### 115.401 (m)
- Was the auditor permitted to conduct private interviews with residents?  
  ☒ Yes  ☐ No

### 115.401 (n)
- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?  
  ☒ Yes  ☐ No
Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency posted the final PREA report of the PREA audit on the agency website. The auditor reviewed the agency website to ensure that previous audit final report has been posted. MonDay has only one facility and the facility is audited in the first year of each audit cycle. This audit is for year one of the new three-year audit cycle.

The auditor was given full access to the facility during the onsite visit. The PREA Compliance Specialist escorted the auditor around the male and female buildings, and opened every door for the auditor. The facility provided the auditor a private room in order to conduct staff and resident interviews. The auditor received documentation on the facility prior to the onsite visit. The auditor was also provided requested documentation during the onsite visit.

The auditor reviewed electronic documentation during the onsite visit. This includes camera views, digital mail, and the resident phone system. The auditor reviewed ten resident files and ten staff files for additional documentation and confirmation of reported information.

Appropriate audit notices were posted in conspicuous areas throughout the facility. These places included areas resident, staff, and visitors would frequent. The notices included the auditors mailing and email addresses. The PREA Coordinator sent the auditor photographic proof of the notices being posted approximately six weeks prior to the onsite visit. The auditor did not receive any correspondence with a staff or resident prior to or after the onsite visit. During the onsite visit, no resident or staff member requested to speak to the auditor.
Standard 115.403: Audit contents and findings

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

115.403 (f)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

The agency has published on its agency website, https://www.mcohio.org/PREA_Audit_Report_2017.pdf, the final audit report from the facility’s 2017 PREA audit. Agency policy requires the facility be audited every three years by a Department of Justice Certified Auditor, and the results of that audit posted on the agency’s website. The PREA Coordinator understands the agency’s obligation to make available to the public the results of the audit. The Coordinator will ensure that the final report from this audit is posted.

In the state of Ohio, all final audit reports are also posted on the Ohio Department of Rehabilitation and Corrections website, https://www.drc.ohio.gov/prea.
AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission. Auditors are not permitted to submit audit reports that have been scanned. See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

[Signature]

December 10, 2019

Auditor Signature

Date

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1 See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110.