PREA AUDIT REPORT ☐ **Interim** ☒ **Final**

COMMUNITY CONFINEMENT FACILITIES

Date of report: 8/16/2016

Auditor Information			
Auditor name: Tina Sallee			
Address: P. O. Box 373, Campbellsville, Kentucky 42718			
Email: r.fields44@ymail.com			
Telephone number: 270-980-2430			
Date of facility visit: 7/19/16			
Facility Information			
Facility name: Hickory Hill Recovery Center			
Facility physical address: 100 Recovery Way, Emmalena, Kentucky 41740			
Facility mailing address: *(if different from above)*			
Facility telephone number: 606-785-0141			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☒ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
ame of facility's Chief Executive Officer: Melissa Estep, Director			
Number of staff assigned to the facility in the last 12 months: 20			
Designed facility capacity: 105			
Current population of facility: 102			
Facility security levels/inmate custody levels: Community Level or Level 1			
Age range of the population: Adult male ages 18 and over			
Name of PREA Compliance Manager:		**Title:**	
Email address:		**Telephone number:**	
Agency Information			
Name of agency: Kentucky River Community Care, Inc.			
Governing authority or parent agency: *(if applicable)*			
Physical address: 115 Rockwood Lane, Hazard, Kentucky 41701			
Mailing address: *(if different from above)*			
Telephone number:			
Agency Chief Executive Officer			
Name:		**Title:**	
Email address:		**Telephone number:**	
Agency-Wide PREA Coordinator			
ame:		**Title:**	
Email address:		**Telephone number:**	

AUDIT FINDINGS

NARRATIVE

ickory Hill Recovery Center located at 100 Recovery Way, Emmalena, Kentucky is a 105-bed recovery program (Alcohol/or Drug Rehabilitation Program for men) located in Knott County, Kentucky. Hickory Hill Recovery Center was opened in December 2014 as a Recovery Kentucky Center as a result of a partnership between several groups, including Kentucky River Community Care, the Kentucky Department of Corrections, the Kentucky Housing Corp. and others. Hickory Hill Recovery Center is a peer driven social model based on the 12 steps of AA using behavior modification through accountability, consequences, classes in Recovery Dynamics as well as open life skills classes and recovery that is comprised of four distinct components of progression (Melissa Estep, Program Director/PREA Coordinator) including: the first distinct component, Safe Off the Streets (SOS) (Natasha Hurley, LPN/SOS/Detox Coordinator/Assistant PREA Coordinator) a safe non-medical environment to withdraw from mood/mind altering substances; Motivational Track (MT) (Josh Tackett, MT Coordinator) where individuals are given the opportunity for success in a structured environment in which to commit to the process of recovery; Phase 1 (Thomas Payne, Phase 1 Coordinator) provides effective solutions to the problems of addiction and is more focused and intense than Motivational Track with goals for Phase I being recovery from the disease of addiction, social wellness and building a positive supportive network by attending self help meetings, completing an array of life skills classes; and the fourth distinct component of progression is Phase II (Kevin Deaton, Phase II Coordinator) which provides reintroduction back into society and prepares a plan of action for living sober as productive members of society. Hickory Hill Recovery Center receives funding from the Kentucky Department of Corrections, Kentucky Housing Development, Community Block Grants, private donations, fundraisers and others. Referrals are received through Kentucky Department of Corrections, local county judges and/or courts, Kentucky Department of Community Based Services (DCBS), Kentucky River Intensive Outpatient Program, Family Care Clinic in Hazard, Cross Roads Clinic, Kentucky Department of Public Advocacy, VA, and volunteers. The facility currently has 102 male residents (age 18 years and over).

This audit was conducted by DOJ Certified PREA Auditor Tina Sallee. During the audit process the auditor reviewed a variety of documents provided by the facility. These included policies and procedures, plans, protocols, training records, curricula, and other documents related to demonstrating compliance with the PREA Community Confinement Standards. The auditor did not receive any correspondence or requests from staff or residents prior to the on-site audit.

An on-site PREA Audit was conducted on Tuesday, July 19, 2016. An entrance meeting was held with Melissa Estep, Program Director/Agency Head Designee/PREA Coordinator/one of two staff trained PREA Investigators/Incident Review Team member). The on-site audit work plan was discussed, samples of residents and staff were selected, and specialized staff were identified. Also, additional pre-audit information was obtained.

Following the entrance meeting a tour of the facility was completed. All areas of the facility were viewed including administration area, classrooms and meeting areas, visitation areas, kitchen and dining area, recreational and outside area, the 2 open bay/dorms and 2 restrooms and other housing units (68 single occupancy rooms with private restrooms - this includes 8 handicapped-accessible rooms with private restrooms). PREA-related informational posters with 1-800 PREA-Hotline number and the Kentucky Association of Sexual Assault Programs (KASAP)/local Jennifer Riley-Bowling at The Rising Center Hazard which provides Rape Crisis services/crisis line contact information were observed posted throughout the facility. Additionally, informational pamphlets and posters regarding PREA with 1-800 PREA-Hotline contact information and the Kentucky Association of Sexual Assault Programs (KASAP) and/or local Jennifer Riley-Bowling at The Rising Center Hazard for Rape Crisis/crisis line contact information were available where staff and residents had access. Pamphlets and posters are printed in English (but were available in Spanish upon request during intake). No SAFE or SANE staff are employed at the facility; however, these professionals are provided at the Hazard Appalachian Regional Hospital Emergency Room, where forensic examinations would be conducted at no cost to the resident and/or their families.

Interviews were conducted with Melissa Estep, Program Director/PREA Coordinator/and also one of two staff trained PREA investigators/Incident Review Team member; Jennifer Miller, Housing Site Manager (Kentucky River Community Care, Inc. – Housing); Tina Begley, Human Resources (Kentucky River Community Care, Inc.); Natasha Hurley, LPN/SOS/Detox Coordinator/Assistant PREA Coordinator/and also one of two staff trained PREA investigators; and six (6) male residents (including one (1) male resident that identified as being gay during his intake/risk assessment), randomly selected.

There has been one (1) allegation/investigation of resident-on-resident sexual contact in the previous 12 months (this was a 3rd party report of two males in facility clothing closet at the same time) report was investigated by Kentucky Department of Corrections and was found "unsubstantiated" (the Incident Review Team did review and has changed protocol regarding use of facility clothing closet). Agency/facility policy and staff interviews confirm that all allegations of sexual abuse and/or sexual harassment are turned over for investigation by both the Kentucky Department of Corrections and/or the Kentucky State Police.

ll residents do receive information on PREA and their right to not be sexually abused and/or sexually harassed, how to report sexual abuse/sexual harassment, their right not to be punished for reporting such immediately upon arriving at the facility. Residents are assessed during intake process to ascertain risk of being sexually victimized and/or abusive and the facility uses this information to keep residents safe. Both intake with PREA educational information and PREA Risk Assessment are conducted by Aaron Collins, Case Worker and/or Natasha Hurley, SOS/Detox Coordinator immediately upon admission to facility. Additionally, after residents are admitted into the facility

they are provided additional information about sexual abuse/sexual harassment during meetings, pamphlets and posters. Residents who have experienced trauma, abuse, or victimization are provided services, as needed, through Kentucky River Community Care Outpatient services.

DESCRIPTION OF FACILITY CHARACTERISTICS

Hickory Hill Recovery Center is located at 100 Recovery Way, Emmalena, Kentucky. The facility was housed in one main building. The facility was clean, in good repair, and well maintained. The building is spacious enough for the staff and the residents, with open hallways nd good lighting. Enter through a front door of the building on the main floor and there is a visitor sign-in area which is adjacent to the administrative area, including offices. The kitchen and dining room area is down the main hall. There are two (2) open bay/dorm housing units (with 16 beds each) with staff monitor desk in each dorm in view of all residents (used for Safe Off The Street (SOS) when residents first come into program and for Motivation Track (MT) residents. There are bathrooms in each dorm with showers – all showers had curtains; and stalls with toilets – all stalls had doors; and sinks. All meeting rooms/offices/classrooms had window/door (on the doors leading to the hallways) for ease of monitoring. There are 68 single occupancy rooms for residents that have advanced through treatment, which have private bathrooms – (each bathroom had shower with curtain over the shower), toilet and sink. There is an outdoor area (including a smoking area and a meditation garden) (has a camera and addition lighting outside for added security).

Posters containing PREA information including the PREA-hotline number are prominently posted on bulletin boards, dining area, hallways, classrooms/meeting rooms, and dorms.

There are currently 12 cameras in common areas including laundry areas, stairwells, and outside (outside has additional lighting) at this facility and the agency/facility continue having on-going discussions regarding continued adequate levels of staffing and/or future possibility of utilizing more cameras in order to continue to protect both residents and staff from sexual harassment/sexual abuse and/or allegations of such. This facility was built and opened in December 2014.

SUMMARY OF AUDIT FINDINGS

The first PREA community confinement facility audit of the Hickory Hill Recovery Center in Emmalena, Kentucky was conducted on Tuesday, July 19, 2016. The audit consisted of data review, staff and resident interviews and facility tour and observations. Documents were timely and complete and included resident assessment forms, resident education acknowledgment forms completed during intake process, staff background screening information as well as staff PREA training records. Staff and resident interviews occurred efficiently. The entire facility was toured. Overall, the facility was well prepared for the audit and performed well in all areas.

Number of standards exceeded: 2

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 2

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

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency/facility has a written policy mandating zero tolerance toward all forms of sexual harassment and/or sexual abuse in the facilty. The policy details the approaches it uses to prevent, detect and respond to sexual harassment and/or sexual abuse in the facility. The definitions of prohibited behaviors are clearly defined, as are the sanctions for those who violate the policy. Policy is thorough and mirrors the PREA language. Policy is in use and staff were able to explain it to the auditor when asked.

The facility has designated a PREA Coordinator Melissa Estep and an Assistant PREA Coordinator Natasha Hurley. They are knowledgeable of PREA requirements/standards, and report they do devote sufficient time and effort in assisting facility staff with PREA-related topics, and have the authority to implement corrective actions to coordinate the facility's compliance with the PREA standards.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NOT-APPLICABLE – this facility does not contract for the confinement of its residents.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In the past 12 months there has been one (1) allegation/investigation of sexual harassment and/or sexual abuse (a 3rd party report of resident-

on-resident sexual contact, report was investigated and found "unsubstantiated"). Staff interviewed voiced that the physical layout of the facility, the composition of the resident population, and other relevant factors are used to calculate adequate staffing levels and to determine eds for further technologies, on an on-going basis for the safety of the residents and the staff. The facility policy meets all the elements of e standard. The staffing plan has been completed and meets all the elements of the standard. Staff and resident interviews and documentation confirmed the practice of supervision and monitoring.

Standard 115.215 Limits to cross-gender viewing and searches

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

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

(a)-(b) There are NO CROSS GENDER strip searches permitted at this facility (it is non-medical). (c) There are NO CROSS GENDER pat searches permitted. There are only male residents and both male and female staff at this facility. (d) All residents have the ability to shower/perform bodily functions/change clothes without being viewed by any staff. All toilets have doors and all showers have curtains. Staff members are posted in each dorm area at staff monitor desk when showers and/or bathrooms are in use. (e) Not Applicable – there have been NO transgender or intersex residents admitted to date. he facility policy prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. (f) All staff are trained in using a professional and respectful manner with transgender and intersex residents per documentation of training and staff reports during interviews (even though they have not had to address this issue to date) they have received training.

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

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

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

Policy has established procedures to provide residents with limited English proficiency and/or residents with disabilities equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual harassment/sexual abuse. If it is determined that residents have limited reading skills, intake staff will read the written materials to the residents. The facility has access to interpreters if/when necessary. There were no residents with disabilities and/or limited English proficient to be interviewed this date.

Standard 115.217 Hiring and promotion decisions

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility conducts extensive background checks and reference checks with multiple entities. There is a policy to conduct background checks verified through documentation and staff interviews. The facility policy addresses all of the elements of this standard.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has NOT made a substantial expansion or modification to existing facility since August 2012 (the facility was built and opened in December 2014). Interview with the Program Director/PREA Coordinator confirmed that any and all modifications/updating to the facility in future is based on the practice of considering the effect upon the facilities ability to protect residents and staff from sexual harressment/sexual abuse and/or allegations of sexual harassment/sexual abuse.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a)-(b) The facility has two trained PREA investigators that are trained and can conduct administrative investigations along with Kentucky Department of Corrections. The name of the agency that has responsibility to conduct criminal investigations would be Kentucky Department of Corrections and/or Kentucky State Police. (c)-(g) The facility offers contact information for Rape Crisis Sevices locally Jennifer Riley-Bowling at The Rising Center Hazard/the Kentucky Association of Sexual Assault Programs (KASAP). Forensic medical exams, when needed, would be conducted at Hazard Appalachian Regional Healthcare Emergency Room, at no cost to the resident or to the resident's families. (h) The Program Director/PREA Coordinator, the SOS/Detox Coordinator/Assistant PREA Coordinator, and documentation confirmed two staff have completed training on investigations of allegations of sexual abuse and the training included: techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in

confinement settings, and the criteria and evidence required to substantiate a case for administrative or prosecution referral.

Standard 115.222 Policies to ensure referrals of allegations for investigations

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

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

The facility policy ensures that an administrative/criminal investigation is completed on all allegations of sexual harassment/sexual abuse. The facility policy requires that all allegations that are criminal in nature are reported to the Kentucky State Police and Kentucky Department of Corrections, an agency with the legal authority to conduct criminial investigations.

Standard 115.231 Employee training

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

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

Documentation and staff interviews indicated that all current staff have completed PREA Training (training included all 10 elements of the subsection) and staff have signed acknowledgment forms (documentation through employee signature that employees received the training). That training is tailored to the gender of the residents and that staff can receive additional training if needed, that all employees are made aware of the facility's no tolerance for sexual harassment/sexual abuse policies and procedures.

Standard 115.232 Volunteer and contractor training

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

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

Policy meets the requirements of the standard. The facility does utilize volunteers, vendors, and contractors, and they are required to complete the PREA training. The facility maintains documentation/acknowledgement forms confirming that volunteers, vendors and contractors sign stating that they understand the PREA training that they have received on their responsibilities under the facility's sexual harassment/sexual abuse prevention, detection, and response policies and procedures.

Standard 115.233 Resident education

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

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

The facility policy is thorough and mirrors the PREA language. PREA education is conducted during intake/risk assessment process with pamphlets, posters on bulletin boards, and documentation of the residents participation in these education sessions with resident signatures verifying they understand the facility's zero-tolerance policy regarding sexual harassment/sexual abuse. Residents acknowledged during interviews they do receive the education upon entering the facility/program, that they understood their rights to be free from sexual harassment/sexual abuse and their right to be free from retaliation for reporting such incidents. Residents were able to discuss various ways they can report an allegation and/or receive services if needed. The agency does provide residents education in formats accessible to all, including those who are limited English proficient or handicapped.

Standard 115.234 Specialized training: Investigations

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

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

The facility has two (2) trained PREA investigation staff, to the extent the facility itself conducts sexual abuse investigations, its investigaters have received training in conducting such investigations in confinement settings. That the specialized training included techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. That this training was provided by the Kentucky Department of Corrections. The name of the agency that has responsibility depending upon the referral source of the residents involved and/or the staff would be Kentucky Department of Corrections for administrative investigations and would be both Kentucky Department of Corrections and/or Kentucky State Police for criminal investigations.

Standard 115.235 Specialized training: Medical and mental health care

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NOT-APPLICABLE. This facility does not employ full-time and/or part-time medical care practioners (upon entering Safe Off the Streets (SOS) the intake staff including LPN/SOS/Detox Coordinator will complete the intake paperwork and go over medication log (if any), and schedules a physical exam at Knott County Rural Health Clinic within 72 hours of admission for a complete health exam. The agency with the authority to conduct forensic examinations would be Hazard Appalachian Regional Healthcare Emergency Room.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Residents are screened during intake for risk of sexual victimization and sexually abusive behavior. The screening instrument contains all 9 criteria to assess residents for risk of sexual victimization and sexually abusive behavior. Documentation of the screening instrument is maintained in each resident file and the facility reassesses the resident's risk of victimization or abusiveness based up on any additional relevant information received by the facility since the intake screening. No resident reported to the auditor that their personal information was used in any exploitative or inappropriate way. The facility policy strictly controls the dissemination of information gathered from the screening.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews indicate that the facility policy reflects PREA language. The facility does use information from the risk screening required by Standard 115.241 to decide housing and program assignments with the goal of keeping all residents safe. To date there have been NO transgender or intersex residents admitted to the facility/program but staff have received training for the possibility in future if the need should arise regarding separate shower/housing/and programming assignments.

`andard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation, staff interviews and resident interviews indicate that the facility policy mirrors PREA language. Residents have multiple internal and external ways to privately report sexual harassment/sexual abuse, retaliation by other residents or staff for reporting sexual harassment/sexual abuse and/or staff neglect or violation of responsibilities that may have contributed to such reports. Staff interviews confirmed that staff can privately report sexual harassment/sexual abuse of resident also. The facility policy is that all staff will accept reports made verbally, in writing, anonymously, and from third parties and promptly document any/all reports.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has an administrative procedure for dealing with resident grievances regarding sexual harassment/sexual abuse. Documentation and staff interviews confirm the facility policy is in line with expectations in subsections: the facility does not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual harassment/sexual abuse; the facility does not requires a resident to use informal grievance processes with the staff of an alleged incident of sexual abuse; the facility ensures that all residents may submit grievance/grievance processes; the facility allows third parties, including family members, attorneys and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse/sexual harassment; the facility policy states that the facility may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith. There have been NO submitted grievances regarding an allegation of sexual harassment/sexual abuse to review in the past 12 months.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility currently uses a local sevice Jennifer Riley-Bowling at The Rising Center in Hazard with a 24 Hour Crisis Line to provide victim advocate and supportive services to residents upon request. The facility, if needed can also refer residents to Kentucky River Community Care outpatient services for mental health evaluation and ongoing counseling. Posters/pamphlets containing contact information are given out during intake process and posted throughout the building for resident and staff information/utilization. Resident interviews confirmed that residents are aware of these services and their right to make contact for services. Residents also have access to family members, sponsors, referral entities, and probation/parole officers.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and interviews confirmed that the facility provides methods to receive third-party reports of resident sexual harassment/sexual abuse and publicly distributes the information on how to report sexual harassment/sexual abuse on behalf of others. PREA pamplets/posters are given to residents during intake/assessment process and posted throughout the building for resident and staff information. Residents have access to family members, sponsors, referral entities, and probation/parole officers.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a)-(e) The facility has policy that requires all staff to report/document immediately any knowledge, suspicion, or information regarding an incident of sexual harassment/sexual abuse that occurred in the facility; to report any retaliation against resident or staff for reporting such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm that when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, the staff have been trained to take immediate action to protect the resident, including but not limited to separating the resident from potential abuser; notifying their supervisor/facility investigators, and completing documentation. All staff expressed that their primary responsibility at all times is the safety of all residents and staff in the facility.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility policy and staff interviews confirm that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Director/PREA Coordinator must notify the head of the facility/appropriate office at the agency where the sexual abuse is alleged to have occurred and requires notifying the appropriate investigative agency immediately.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility policy and staff interviews confirm that policy does cover all required elements of staff first responder duties/training and staff could articulate the steps they are to take when responding to an incident of sexual abuse.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility's detailed coordinated response plan and staff interviews confirm facility policy/training for actions required in response to an incident of sexual abuse among staff first responders, investigators, and facility leadership.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NOT-APPLICABLE. The facility does not participate in any collective bargaining agreements.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility documentation and staff interviews confirm agency protection against retaliation and zero-tolerance for retaliation – there have been no reports of incidents of retaliation in the past 12 months.

tandard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy is in line with the PREA Standard subsection language. The facility policy requires that all allegations of sexual harassment or sexual abuse be referred for investigation to an agency with the legal authority to conduct criminal investigations (Kentucky State Police) and (Kentucky Department of Corrections) and/or administrative investigations (Kentucky Department of Corrections for probation/parole residents) and/or two trained PREA investigators (staff members). Investigations are conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports; the credibility of an alleged victim, suspect or witness would be assessed on an individual basis and shall not be determined by the person's status as resident or staff; investigations include an effort to determine whether staff actions/failures to act contributed to the abuse; documentation is immediate and includes a description of the physical and testimonial evidence, investigative facts and findings; the facility retains all written reports; the departure of the alleged abuser or victim from the employment or control of the facility does not provide a basis for terminating an investigation; the facility cooperates with outside investigators and remains informed about the progress of any investigation until its conclusion/finding and is notified in writing.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy is in line with the PREA Standard language. The facility shall impose no standard higher that a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated for administrative investigations.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

ocumentation and staff interviews confirm facility policy is in line with the PREA Standard language, including but not limited to the acility, following an investigation into a resident's allegation of sexual harassment/sexual abuse suffered in the facility, shall inform the resident as to whether the allegation has been determined to be "substantiated, "unsubstantiated", or "unfounded". If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident. All such notifications and/or attempted notifications shall be documented. (f) A facility's obligation to report under this standard shall terminate if the resident is released from the facility's custody.

Standard 115.276 Disciplinary sanctions for staff

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

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

Documentation and staff interviews confirm facility policy that staff who violate agency zero tolerance sexual harassment/sexual abuse policies are subject to disciplinary action. Disciplinary actions include but are not limited to a variety of sanctions, including termination. The facility policy requires all allegations of sexual abuse to be reported to the Kentucky State Police, regardless of whether the staff resigns - is terminated.

Standard 115.277 Corrective action for contractors and volunteers

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

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

Documentation, and staff interviews confirm facility policy that all volunteers, vendors, and contractors are trained/sign an acknowledgment form stating they understand the zero tolerance policy for sexual contact with residents and informed how to report any knowledge, suspicion, or information regarding sexual harassment/abuse that occurred in the facility directly to the Program Director/PREA Coordinator/trained PREA investigator and/or to the SOS/Detox Coordinator/Assistant PREA Coordinator/trained PREA investigator. Any volunteer, vendor and/or contractor who were to engage in sexual abuse would be prohibited from contact with residents and reported to law enforcement immediately.

tandard 115.278 Disciplinary sanctions for residents

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirm facility policy that all residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse including but not limited to a referral for criminal investigation/possibility of criminal charges. Administrative sanctions are commensurate with the nature and circumstances of the abuse committed; the resident's disciplinary history, whether a resident's mental disabilities and/or mental illness contributed to the behavior; whether or not the resident is on probation/parole (placement could be terminated).

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facilty policy requires that all resident victims of sexual abuse shall have access to unconditional, immediate emergency medical and mental health services at no cost to the resident and/or the resident's family.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy requires that all resident sexual abuse victims and/or abusers shall have access to unconditional ongoing medical and mental health care including but not limited to evaluation and treatment and shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care (consistent with the community level of re).

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy identifies staff that serve on an Incident Review Team that includes upper-level management officials, with input from all staff including two facility investigators and others. The review team considerations of any allegations would include but not be limited to the following: whether the allegation or investigation indicated a need to change policy or practice to better prevent, detect, or respond to sexual abuse; whether the incident or allegation was motivated by race, ethnicity, gender identity, status or perceived status, or whether it was motivated or otherwise caused by other group dynamics at the facility. The review team would examine the area where the incident allegedly occurred to assess physical layout; assess the adequacy of staffing levels in that area during different shifts; and assess whether monitoring technology should be deployed in future. The review team would document its findings in an annual report.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy requires facility collect accurate, uniform data for every allegation of sexual harassment/sexual abuse at the facility using a standardized instrument and set of definitions provided by the Kentucky Department of Corrections. The facility does maintain, review and collect data as needed from all available incident-based documents and provides monthly reports to the Kentucky Department of Corrections.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation and staff interviews confirmed facility policy to review data collected pursuant to PREA Standard 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training including but not nited to identifying problem areas, taking corrective action on an on-going basis, and preparing an annual report of its findings. The ıacililty report is approved by the agency head.

Standard 115.289 Data storage, publication, and destruction

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

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

Documentation and staff interviews confirmed facility policy that ensures data collected pursuant to PREA Standard 115.287 are securely retained. The facility removes all personal identifiers and maintains sexual abuse data collected for at least 10 years after the date of the initial collection.

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Tina Sallee _____ 8/16/16 _____

Auditor Signature Date