PREA AUDIT: AUDITOR'S SUMMARY REPORT
COMMUNITY CONFINEMENT FACILITIES

Name of facility:	Spencer House Men's Recovery Center			
Physical address:	69 Granville Street, Newark, OH 43055			
Date report submitted:	2/9/15			
Auditor Information				
Address:	124 Dennis Drive, Cortland, OH 44410			
Email:	bnjmorg@hotmail.com			
Telephone number:	330-219-4453			
Date of facility visit:	8/11/14			
Facility Information				
Facility mailing address: *(if different from above)*	Same			
Telephone number:	740-522-8477			
The facility is:	☐ Military	☐ County	☐ Federal	
	☐ Private for profit	☐ Municipal	☐ State	
	X☐ Private not for profit			
Facility Type:	☐ Community treatment center X☐ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community based confinement facility ☐ Mental health facility	☐ Other:	
Name of Facility Head:		Sharon Stockton	**Title:**	Program Director
Email address:		sharonstockton@bhcpartners.org	**Telephone number:**	740-349-1810
Name of PREA Compliance Manager (if applicable):		N/A	**Title:**	N/A
Email address:		N/A	**Telephone number:**	N/A
Agency Information				
Name of agency:	Behavioral Healthcare Partners of Central Ohio			
Governing authority or parent agency: *(if applicable)*	Ohio Department of Rehabilitation and Correction			
Physical address:	77 Granville Street, Newark, OH 43055			
Mailing address: *(if different from above)*	Same			
Telephone number:	740-522-8477			

Agency Chief Executive Officer			
Name:	Patrick Evans	**Title:**	President & Chief Executive Officer
Email address:	patrickevans@bhcpartners.org	**Telephone number:**	740-522-8477
Agency-Wide PREA Coordinator			
Name:	Lisa Pertee	**Title:**	Continuous Quality Improvement Director
Email address:	lisapertee@bhcpartners.org	**Telephone number:**	740-788-3421

AUDIT FINDINGS

NARRATIVE:

A Community Confinement Facility audit was conducted on August 11 and 12, 2014 of The Spencer House Men's Recovery Center located at 69 Granville Street, Newark, OH. The following upper level staff member positions were present during the audit: Continuous Quality Improvement Director/PREA Coordinator, Chief Human Resources Officer, Program Director, and Chief Operating Officer.

The Spencer House is a halfway house that is operated by the Behavioral Healthcare Partners of Central Ohio, Inc. They accept referrals from the criminal justice system, social service organizations and other treatment professionals, as well as self-referrals. Spencer House accepts male adult clients over the age of 18 who are felony offenders sentenced by the common pleas courts of Licking and Knox Counties. Additionally, they accept misdemeanor offenders and self-reporting individuals in need of their services. Behavioral Healthcare Partners receives funds from the Ohio Department of Rehabilitation and Corrections, Licking County United Way and the Community Mental Health and Recovery Board.

The program is facilitated using Cognitive Behavioral Therapy and uses programs to address chemical dependency, anti-social thinking and behavior and job readiness.

DESCRIPTION OF FACILITY CHARACTERISTICS:

There were 17 residents in house at the time of the audit. The Resident Aide Team Leader escorted me around the inside and outside of the Spencer House for a tour. During the tour there was a treatment group being conducted and there were three (3) other staff in the house along with the Resident Aide. The Resident Aide is responsible for all security/operational aspects of the house. The counselors on duty provide individual counseling, case management services and facilitate treatment groups. There is also a House Director who provides supervision to the entire house.

There were 14 cameras placed strategically throughout the house. View of the cameras is located at the staff post immediately as you enter the house. The residents have three (3) recreation areas where they are able to read, watch television, play board games, video games, pool and exercise. The recreation areas are on the main floor, the basement and the upper floor. Additionally the residents are also permitted to use the outside backyard as a recreation area during the day until 9:00pm at which time they need to seek staff permission to go outside. The main level consists of the staff post, the kitchen, the dining room, a recreation room, a group room and a counselor's office. The basement consists of the exercise room, recreation room and laundry room accessible to residents. The two upper floors comprise the resident bedrooms as well as staff offices and another small recreation area where they

are able to watch television or play video games as earned through the facility's Behavioral Management System.

All resident bedrooms and private restrooms are located on the second and third floor. Each restroom is a single use restroom with a door and privacy for all residents to change their clothing, take a shower, and perform bodily functions without being viewed by anyone else.

Informational posters about PREA were found on each level of the house in plain view to all residents, staff and visitors. Posters contained contact information inclusive of telephone numbers and an email address for the facility PREA Coordinator and a toll free number to the Mental Health & Recovery Board for Licking and Knox Counties.

SUMMARY OF AUDIT FINDINGS:

The audit revealed that The Spencer House met 33 standards (6 of which are non-applicable), exceeded one (1) standard and did not meet five (5) standards, thus requiring Corrective Action Plans. All Corrective Action Plans were submitted, thus at the time of this final report, the facility has met all 39 standards with two (2) exceeding the standard and six (6) being non-applicable.

I interviewed a random sample of five (5) residents from the Spencer House. None of these residents were limited English speaking, had any disabilities, reported any sexual abuse or sexual harassment claims or were identified as being Gay, Bisexual, Transgender, Intersex, or Gender Non-Conforming. The facility had no residents with these characteristics placed in their house at the time of the audit.

I interviewed a random sample of one (1) Resident Aid Team Leader, one (1) Counselor and the House Director in addition to the PREA Coordinator, the Program Director, the Chief Human Resources Officer and the Chief Operating Officer.

Number of standards exceeded: 2

Number of standards met: 37 (inclusive of six (6) Non-Applicables)

Number of standards not met: 0

Standard number here	115.211

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy mandating zero tolerance for sexual harassment for staff and residents. The policy outlines the facility's approach to preventing, detecting, and responding to such conduct. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. Sanctions for individuals participating in such behaviors are also outlined in the policy. Finally the policy includes the facility's strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents and staff members.

115.211 (b)

Meets standard

There is a letter in the file of the Continuous Quality Improvement Director appointing her as the PREA Coordinator for the facility. She is a member of upper-level management with sufficient time and authority to develop, implement, and oversee the facility's efforts to comply with the PREA standards. During her interview with me she identified that she has ample time to oversee the facility's efforts to comply with the PREA standards and that the other members of the management team work well together to ensure the facility's compliance.

Standard number here	115.212

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

Non-Applicable

The Spencer House does not contract with private agencies or other entities for the confinement of it's residents.

Standard number here	115.213

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a documented Staffing Plan that provides for adequate levels of staffing and video monitoring to protect the residents against sexual abuse. The Staffing Plan includes the minimum amount of staff members needed to successfully operate the Spencer House 24 hours a day, 7 days a week, 365 days of the year and further identifies a male staff member must be present at all times in the Spencer House. The staffing plan takes into consideration the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse and any other relevant factors.

The facility also has a policy that further directs that any deviations from the established Staffing Plan must be documented and justified. The policy addresses a review of the Staffing Plan no less frequently than once per year in order to assess, determine and document whether adjustments are needed to the Staffing Plan based on prevailing staffing patters, video monitoring systems and other monitoring technologies and the resources available to commit to ensure adequate staffing levels.

The facility provided further documentation of meeting minutes in which the Staffing Plan was reviewed with members of the management team including the PREA Coordinator. The meeting identified the need for additional video surveillance in order to provide for more coverage of the residents in the facility. The request was submitted to the Ohio Department of Rehabilitation and Correction for review.

Standard number here	115.215

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy stating that no staff member shall perform any type of personal search of any resident's body except in emergency situations where there is a threat to any resident or staff member and only after approval from the Program Director or supervisor in charge. These emergency pat down searches will only be conducted by a staff member of the same sex of the resident being searched. The facility prohibits strip searches and body cavity searches no matter the circumstances. Aside from the emergency pat down searches, the policy only permits the search of the resident's personal belongings during a routine search of the facility. The facility requires that the resident's empty their pockets if they are displaying suspicious behavior or upon their return from a business pass.

A random sample of staff confirmed this policy is put into practice as each stated that they do not conduct any type of personal search and only search the resident's personal belongings. They also confirmed that they are to never conduct a pat down search of a resident of a different gender as themselves. Each staff confirmed that there has never been an emergency situation in which they had to conduct an actual pat down of a resident's person. Each staff member interviewed has been trained on the facility's policy regarding searching residents. No documentation of searches is made as the policy prohibits personal searches.

A random sample of resident's confirmed this policy as well as each stated that they have never received a pat down by a staff member and stated that there is always a male staff member on duty so they know they would only be searched by a male staff member if the need arose.

The facility has a policy enabling the residents to shower, perform bodily functions, and change their 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 staff checks. The policy also requires staff to knock and announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

A tour of the facility showed that all restrooms are single use with a door allowing for total privacy for residents to change their clothing, perform bodily functions and shower without staff of the opposite gender viewing them.

This policy was verified through random interviews with staff and residents. All residents and staff members interviewed reported that staff members of the opposite gender always knock and audibly announce their presence when entering the bedroom/restroom areas of the facility where the residents are permitted to change clothing and perform bodily functions. All residents identified that they are aware that they are only permitted to change their clothing in the restroom or in their bedroom. All residents interviewed stated that they have never been viewed by staff members of the opposite gender while they were changing clothing, performing bodily functions or showering.

The facility does not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. They have a policy that prohibits this behavior from occurring. The resident's genital status is known prior to their intake to the facility.

The facility trains their staff members on their no pat down policy except in emergency situations. Each staff interviewed is aware of the policy and stated that they have never conducted a pat down search of a resident. Staff are additionally trained to conduct personal property searches of the resident's property in a professional, respectful and non-intrusive manner. Each staff interviewed stated that they would never conduct a pat down search of a resident of a different gender than themselves.

Standard number here	115.216

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has established procedures as well as a policy that provides disabled residents 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.

The facility has entered into a Memorandum of Understanding with ASIST Translation Services to provide it's residents with interpretation services whenever necessary. This service includes audio translation as well as written translation if and when necessary.

All staff members interviewed were able to explain to me how the facility would use the services of ASIST in order to provide translation services to any resident in need. Additionally each staff member stated that they take time to read information to any resident that has been deemed to have limited reading/writing/comprehension skills. A couple of the staff members recounted a time years ago when

they had a deaf resident and in order to ensure he gained the most from his program they provided a sign language interpreter during his residency.

All residents interviewed stated that they knew of the facility's ability to help them understand any material that would prohibit them from gaining the most from their individual program. They stated that a staff member explained the PREA posters to them if they had any questions. Further they stated that staff has helped them with understanding their homework or class assignments when they needed it.

The facility also has a written policy preventing the use of resident readers, resident interpreters 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-responder duties or the investigation of the resident's allegations.

Each resident interviewed stated that staff has helped them with any questions they have had regarding PREA. Each staff interviewed stated that they would only use a resident interpreter in the event of a dangerous situation that would compromise the safety of residents or staff members.

The facility has not had the need to use the services of ASIST to provide for interpretation services in the past year so no documentation was available.

Standard number here	115.217

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

(a) (b)

Meets Standard

The facility has a policy on the hiring and promoting procedures of Behavioral Healthcare Partners. The policy includes that the facility will not hire or promote anyone who may have contact with residents or enlist 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 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; or has been civilly or administratively adjudicated to have engaged in the activity descripted in paragraph (a)(2) of standard 115.217. The facility further asks these questions upon all employees and applicants and has documentation of such in personnel files. This information was further verified during the interview with the Chief Human Resources Officer.

The facility considers 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. The Chief Human Resources Officer verified that the facility conducts this procedure across the board for everyone including volunteers and interns.

(c)

Does not meet standard, corrective action plan required

While the facility performs a criminal background check before hiring all new employees, they do not make their 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. During the interview with the Chief Human Resources Officer she assured me that the facility does it's due diligence in contacting prior references of any applicant, however, they also consider the applicant's status at their current place of employment and respect the wishes of the applicant in not contacting them if so desired. The Chief Human Resources Officer stated that all changes to the Human Resources policy and procedure must be reviewed and approved by their Governing Board.

The Corrective Action Plan requires the facility to either make changes to their existing policy to make it's best efforts to contact previous institutional employers or to document a federal, state, or local law that prohibits it from having to do so. The Chief Human Resources Officer and the PREA Coordinator will see this Corrective Action Plan through and submit the necessary documentation to me by February 2, 2015, which is consistent with the 180 Corrective Action Plan requirements.

CORRECTIVE ACTION PLAN:

On February 2, 2015, the PREA Coordinator submitted a revised Policy stating that the facility will make it's best efforts to contact previous institutional employers regarding allegations of substantiated sexual abuse or any resignation during an ongoing investigation into allegations of sexual abuse. The Policy was approved by the Facility Governing Board and put into effect as of February 2, 1015. Therefore, section "c" of this standard now meets the standard.

(d) (e) (f) (g) (h)

Meets Standard

The facility conducts a criminal background records check before enlisting the services of anyone, including contractors, who may have contact with residents. Documentation of such records checks was found in personnel files as well as verified through interviews with staff members and the Chief Human Resources Officer.

The facility has a policy that requires a criminal background records check of anyone who may have contact with residents every five (5) years. Further, the policy and facility code of ethics requires that all staff members inform the Chief Human Resources Officer of any contact that they may have had with law enforcement officials.

The facility asks all applicants and employees who have contact with residents directly about previous misconduct described in paragraph (a) of 115.217 in written applications as well as in phone and face to face interviews with the applicants. The facility imposes upon all employees a continuing affirmative duty to disclose any such misconduct. Verification of this was provided via a phone interview screening form from a potential applicant on March 23, 2014.

The application for employment form clearly states that material omissions regarding such misconduct, or the provision of materially false information, are grounds for termination if already hired and grounds for disqualifying them as a potential employee if an applicant.

The facility has a policy in place describing how they will 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. The policy only permits the Chief Human Resources Officer, the Senior Vice President and Chief Operating Officer and the President and Chief Executive Officer as the only people authorized to release any type of information in regards to a reference check. Through interviews with the Chief Human Resources Officer and the Chief Operating Officer, they both confirmed that they would release such information upon request from an institutional employer.

Standard number here	115.218

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

(a) Non-Applicable

The facility has not designed or acquired any new facility nor have they planned any substantial expansion or modification of their existing facilities since August 20, 2012.

(b)

Meets Standard

The facility has considered how technology may enhance the facility's ability to protect residents from sexual abuse when installing or updating a video monitoring system. The facility submitted a grant submission to the Ohio Department of Rehabilitation and Correction seeking additional cameras in order to provide better protection for the residents against sexual abuse. The proposal was submitted on July 22, 2014 and they have not heard back yet regarding the decision. During their Staffing Plan meeting these cameras were identified as having the ability to provide better prevention regarding sexual abuse of the residents. During my tour of the facility I also identified the same potential blind spots. In the mean time they have staff members conducting random tours of these areas. My interviews with staff confirmed that they are making their presence known in these areas until they are able to reach a decision from the Ohio Department of Rehabilitation and Correction for their cameral proposal.

Standard number here	115.221

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

(a) (f)

Meets Standard

The facility has a policy that it will investigate all allegations of sexual harassment and sexual abuse. The facility's PREA Coordinator is responsible for conducting an administrative investigation into all allegations of sexual harassment/sexual abuse. The facility has a Memorandum of Understanding with the Newark Police Department to conduct a criminal investigation into all allegations of sexual abuse. The facility's policy states that they will request that the Newark Police Department follow all guidelines set forth in 115.221.

(b)

Meets Standard

The facility is non-applicable regarding protocol being developmentally appropriate for youth as they only house adult males age 18 and over.

The facility does comply with the protocol being 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.

(c)

Meets Standard

The facility has a policy that ensures that all victims of sexual abuse will be offered access to forensic medical examinations at Licking Memorial Health Systems, without financial cost to the victim, where evidentiarily or medically appropriate. Such examinations will be performed by Sexual Assault Forensic Examiners (SAFE's) or Sexual Assault Nurse Examiners (SANE's). If SAFE's or SANE's cannot be made available, the examination can be performed by other qualified medical practitioners.

The facility has entered into a Memorandum of Understanding with the Licking Memorial Health Systems to provide emergency care to any individual who reports being sexually assaulted/abused while at the Spencer House. The MOU further states that the victims will be given an examination by a SAFE or a SANE and that the cost of services will 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 had no allegations of sexual abuse within the past 12 months therefore there was no documentation speaking to the number of forensic medical exams conducted or performed by SAFE's or SANE's.

(d) (e)

Meets Standard

The facility has a policy outlining that it will use the services of the Licking County Rape Crisis Center to provide advocacy services to residents of the Spencer House. Additionally it has a Memorandum of Understanding with the Licking County Rape Crisis Center detailing such. If a member of the Rape Crisis Center is not available, the facility has numerous qualified Professional Counselors who's scope of practice allows them to treat victims of sexual abuse. This qualified staff member would serve as an

advocate for the victim and provide support to them throughout the investigative process and thereafter to ensure continuity of care. The facility has documented proof of licensure for these qualified staff members.

As requested by the victim, the victim advocate or qualified agency staff member will accompany and support the victim through the forensic medical examination process and investigatory interviews and will provide emotional support, crisis intervention, information and referrals.

Memorandums of Understanding with the Newark Police Department, the Licking County Rape Crisis Center and the Licking Memorial Health Systems were all provided as documentation. Additionally my interviews with the PREA Coordinator, the Program Director, the Chief Human Resources Officer and the Chief Operating Officer verified this is the process that takes place for any allegation of sexual abuse or sexual harassment.

Standard number here	115.222

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

(a) (b)

Meets Standard

The facility has a policy to ensure that the PREA Coordinator will conduct an administrative investigation into all allegations of sexual harassment/sexual abuse. The facility also has a policy to ensure that all allegations of sexual abuse will be referred to the Newark Police Department for criminal investigation and that these referrals will be documented.

Documentation of this policy was evidenced by the Memorandum of Understanding entered into with the Newark Police Department as well as the interviews with the PREA Coordinator, the Program Director, the Chief Human Resources Officer and the Chief Operating Officer. Additionally this policy is published on the facility's website.

The facility has had no allegations of sexual abuse or sexual harassment within the past 12 months.

(c) (d) (e)

Non-Applicable

The Spencer House is not responsible for conducting criminal investigations, nor is it a State entity or a Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment.

Standard number here	115.231

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

(a) (b) (c) (d)

Does Not Meet Standard, Corrective Action Plan required

The facility has a documented curriculum developed that is designed to train all employees who may have contact with residents. Such curriculum contains:

1. It's zero tolerance policy for sexual abuse and sexual harassment
2. How to fulfill their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, reporting and response policies and procedures
3. Residents' rights to be free from sexual abuse and sexual harassment
4. The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment
5. The dynamics of sexual abuse and sexual harassment in confinement
6. The common reactions of sexual abuse and sexual harassment victims
7. How to detect and respond to signs of threatened and actual sexual abuse
8. How to avoid inappropriate relationships with residents
9. How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and
10. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities

The training curriculum is tailored toward the gender of the residents at the Spencer House. Policy states that all employees will receive additional training if the employee is reassigned from the Spencer House to another part of the Behavioral Healthcare Partners agency that houses female residents. Policy further states that all current employees who have not received such training will be trained within one year of the effective date of the PREA standards, and the agency will 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. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

While the facility has these policies and training curriculum, they have not yet trained their staff members, therefore, no documentation was provided. The facility has recently re-designed their entire staff training program and hired a new staff member to oversee this program. This is one of the main reasons why the training program was not provided to the staff members at the time of the audit.

The PREA Coordinator, the Program Director and the Chief Operating Officer assured me that within the 180 day corrective action period they will have all of their staff members trained regarding the PREA standards.

The Corrective Action Plan requires that the facility train all staff members on their PREA curriculum and provide documentation through staff training verification forms that the employees have been trained and that they understood the training that was provided to them. This is to be conducted by the PREA

Coordinator and submitted to me by February 2, 2015 which is in compliance with the 180 day corrective action plan period requirement.

CORRECTIVE ACTION PLAN:

The PREA Coordinator submitted documentation of staff training verification forms on February 2, 2015. Additionally the training curriculum was also submitted and covered all of the required areas as outlined in "1-10" of this standard. As of December 2014, all staff members of the Spencer House have been trained on the PREA Curriculum and understand the training that was provided to them. Therefore, this standard now Meets Standard.

Standard number here	115.232

X☐ 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 comments, including corrective actions needed if does not meet standard

Does Not Meet Standard, Corrective Action Plan required

The facility has a policy that all volunteers and contractors who have contact with residents be trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection and response policies and procedures. The policy further states that the level and type of training provided to the volunteers and contractors will be based on the services that they provide and the level of contact they have with residents, but all volunteers and contractors who have contact with residents will be notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

While the facility has this policy as well as a curriculum designed to meet this standard, it has not provided the training to any of it's volunteers or contractors. Similar to standard 115.231, the facility has recently re-designed their entire training program and hired a new staff member to oversee this program. This is one of the main reasons why the training program was not provided to the volunteers and contractors at the time of the audit.

The PREA Coordinator, the Program Director and the Chief Operating Officer assured me that within the 180 day corrective action period they will have all of their volunteers and contractors who may have contact with residents trained regarding the PREA standards.

The Corrective Action Plan requires that the facility train all volunteers and contractors who may have contact with residents on their zero tolerance policy regarding sexual abuse and sexual harassment and that they be informed on how to report such incidents. Further the volunteers and contractors will receive additional training consistent with the services they provide and the level of contact they have with the residents. Finally, the facility will provide documentation through training verification forms that the volunteers/contractors have been trained and that they understood the training that was provided to them. This is to be conducted by the PREA Coordinator and submitted to me by February 2, 2015 which is in compliance with the 180 day corrective action plan period requirement.

CORRECTIVE ACTION PLAN:

The PREA Coordinator submitted documentation of volunteer and contractor training verification forms on February 2, 2015. Additionally the training curriculum was also submitted and covered all of the required areas as outlined in "1-10" of standard 115.231. As of December 2014, all volunteer and contractors who may have contact with the residents of the Spencer House have been trained on the PREA Curriculum and understand the training that was provided to them. The training provided was the same as that provided to the staff members of the Spencer House, therefore, this standard now "exceeds the standard".

Standard number here	115.233

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

Does Not Meet Standard, Corrective Action Plan required

The facility does not have a policy on what information the residents will be given during the intake process. The residents were not given formal education explaining the facility's zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents and regarding the facility's policies and procedures for responding to such incidents.

During my interviews with the residents they were very knowledgeable on the facility's policy on zero tolerance regarding sexual abuse and sexual harassment and they also knew who to report such issues to. When asked where they obtained this information they stated that they read it on the posters posted throughout the house. No formal training was given to them by staff nor were any of the residents interviewed given any information regarding PREA during their intake into the facility.

The Corrective Action Plan requires that the facility formally educate all residents on their zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents and regarding the facility's policies and procedures for responding to such incidents. They will have each resident sign that they have received such education and that they understand the information that was provided to them. This documentation needs to be signed by each resident and placed in their respective case file.

The facility also needs to implement this educational information into their intake process for the residents. The facility has this information provided in the form of a pamphlet as well as in their Resident Handbook; they have just not implemented this yet. The facility will need to implement giving each resident the PREA pamphlet as well as have them sign off on their Resident Handbook after they have been explained such information during their intake process. The sign off sheet needs placed in each resident's file.

The facility also needs to develop a policy that states that each resident will be provided the above information during their intake process. The policy also will state that the residents will sign a sheet to be placed in their file that they have received the above educational information on PREA and that they understand the information that was provided to them. When necessary the facility will need to provide this information in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, otherwise disabled, as well as to residents who have limited reading skills. This shall be provided via their Memorandum of Understanding with ASIST Translation Services.

Finally, the PREA Coordinator will ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

This Corrective Action Plan is to be conducted by the PREA Coordinator and submitted to me by February 2, 2015 which is in compliance with the 180 day corrective action plan period requirement.

CORRECTIVE ACTION PLAN:

The PREA Coordinator submitted documentation that the Spencer House formally educated all residents on their zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents and regarding the facility's policies and procedures for responding to such incidents. Additionally documentation was provided showing that each resident signed that they have received such education and that they understood the information that was provided to them. This documentation was signed by each resident and placed in their respective case file.

They have also implemented this information into their intake process for all new residents entering the Spencer House and will place documentation of such training in each resident's respective case file. The PREA Coordinator also submitted the facility's policy documenting such. All required documents have been submitted for this Corrective Action Plan, therefore, this standard now meets the standard.

(b)

Non-Applicable

The facility does not transfer their residents to a different facility during their placement at the Spencer House. If they are transferred it will be to a facility not in the Behavioral Healthcare Partners System.

Standard number here	115.234

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility conducts an Administrative Investigation into all allegations of sexual abuse and sexual harassment. All investigations with the potential to become criminal are referred to the Newark Police Department for a criminal investigation to be conducted.

While the PREA Coordinator will not be conducting criminal investigations into sexual abuse allegations, she has received training in conducting sexual abuse investigations in confinement settings. This is documented through a certification on Specialized Investigator Training as well as a certificate on Victim Support Person Training. Both trainings were provided by the Ohio Department of Rehabilitation and Correction's Assistant Chief Inspector. Documentation of these training certificates was found in the PREA Coordinator's training file. Additionally the PREA Coordinator has received extensive training regarding PREA throughout the past year. Documentation of all of her training was found in her training file during the on-site portion of the audit. During her interview with me she was able to explain all of the knowledge that she has gained regarding PREA from these trainings and was found to be very knowledgeable in the PREA standards and how the facility will comply with them.

The specialized training curriculum 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.

(d)

Non-Applicable

The facility is not a state entity or a Department of Justice component that investigates sexual abuse in confinement settings, therefore, they do not need to provide such training to its agents and investigators who conduct such investigations.

Standard number here	115.235

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

Does Not Meet Standard, Corrective Action Plan required

The facility employs mental health care practitioners who work regularly in its facilities, however, they have not received training on: 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 and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

Other than the metal health practitioner's licensure, no further documentation was found regarding such training. Further the metal health practitioners have not received any training regarding PREA that is mandated for employees under 115.231.

The Corrective Action Plan requires the PREA Coordinator to ensure that all mental health practitioners who work regularly in the Spencer House will be trained on the above specialized training as well as the

training mandated for all employees under 115.231. Such training can be provided by the Behavioral Healthcare Partners or elsewhere. Each mental health practitioner will need to sign a training form or provide documentation in the form of a certificate that they have received this training and that they understand the information that was provided to them. Verification of this documentation will need to be placed into each mental health practitioners training or personnel file. The PREA Coordinator will need to send me the curriculum for this specialized training to ensure all areas required by the standard were covered as well as verification that each mental health practitioner received and understood the training.

This Corrective Action Plan is to be conducted by the PREA Coordinator and submitted to me by February 2, 2015 which is in compliance with the 180 day corrective action plan period requirement.

CORRECTIVE ACTION PLAN:

The PREA Coordinator submitted documentation that the mental health care practitioners have received training on 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 and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Verification of this training was provided as well through the training material presented as well as the training verification sheets signed by the mental health staff. Documentation was provided showing that all mental health care practitioners have received the mandated training under 115.231 as well as the specialized training for mental health care practitioners, therefore, this standard now “meets the standard”.

(b)

Non-Applicable

The facility does not have medical staff employed by the agency to conduct forensic examinations. All medical examinations will be provided by a SAFE or a SANE at the Licking Memorial Health System via their Memorandum of Understanding with the hospital.

Standard number here	115.241

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The Spencer House policy requires that a screening assessment of all residents will be conducted during their intake. The screening assessment is an objective screening instrument that is conducted by a member of the treatment staff and ordinarily within 72 hours of the resident’s admission to the facility. The screening assessment is used to determine each resident’s risk of being sexually abused by other residents or sexually abusive toward other residents.

The screening assessment considers, at a minimum, the following criteria to assess residents for risk of sexual victimization:

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 been previously incarcerated
5. Whether the resident's criminal history is exclusively nonviolent
6. Whether the resident has prior convictions for sex offenses against an adult or child
7. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex or gender nonconforming
8. Whether the resident has previously experienced sexual victimization and
9. The resident's own perception of vulnerability

The screening assessment also considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence of sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive.

The facility has a policy that states that no resident will be 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 standard.

The facility has a policy stating that each resident is reassessed for their risk of victimization or abusiveness within a set time period, not to exceed 30 days from their arrival at the facility. This shall be based upon any additional, relevant information received by the facility since the intake screening. Additionally a resident's risk will be reassessed 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. Policy also states that staff shall immediately take action to protect residents if staff learns that a resident is subject to a substantial risk of imminent sexual abuse.

The facility controls which staff members have access to the screening assessment information. They have a reporting system that informs them each time any staff member accesses a resident's file electronically. The paper files are kept in the house and each staff member working in the house has access to the file. No sensitive information is exploited to the resident's detriment by staff or other residents.

During my interview with the House Director, PREA Coordinator and Chief Operating Officer, they all explained the screening process and were very knowledgeable with how the information was used. The screening assessment is very detailed and is designed to obtain information that will be beneficial to the resident's programs. It covers every area of the resident's life such as their mental health treatment history, chemical dependency treatment history, criminal involvement history, abuse history, as well as their suicidal risk and abuse history risks. It appears to be a highly effective objective screening instrument that allows them to plan an appropriate treatment plan for each resident.

A review of randomly picked files assured that the intake screenings were ordinarily conducted within 72 hours of the resident's arrival to the facility. Each resident interviewed explained the detailed screening process that they went through and felt that staff was very professional in how they conducted the process and that they sought the input of the resident into the assessment as well. The policy on the screening assessment as well as interviews with staff and residents confirmed that this screening assessment is being used properly and in accordance with the standards in order to obtain information regarding each resident's risk of being victimized or abusive.

Standard	115.242

number here	

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The Spencer House uses the screening information obtained in 115.241 to inform housing, bed, work, education and program assignments 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 screening assessment is designed to allow the user to make individual determinations about how to ensure the safety of each resident due to the type of questions they ask about all aspects of the resident's life in addition to the staff's perception and the resident's perception of their risk level. The House Director, the Program Director, the PREA Coordinator and the Chief Operating Officer were able to explain in detail how the screening assessment information is used and how individualized decisions are made according to each resident's assessment.

Although the facility has not had a transgender or intersex resident, the PREA Coordinator and the Chief Operating Officer were able to explain to me that the decision to house such a resident would be on a case-by-case basis and would ensure the resident's safety and health and would also consider whether the placement would present management or security problems. They each assured me that they would not place a lesbian, gay, bisexual, transgender or intersex resident in a facility based solely on the basis of such identification or status unless such placement is in a dedicated facility in connection with a consent decree, legal settlement or legal judgment for the purpose of protecting such residents. They each explained in detail how their residents are selected for placement into their facility. Additionally the screening assessment allows for each resident to present information that speaks to their own view of his/her own safety. This information is given significant weight with respect to how the screening assessment is used to make individualized decisions for each resident.

Through a tour of the facility, each restroom is private and allows for all residents to shower separately from other residents. Bedrooms are also private with some only housing two (2) residents to a room. The facility is able to move any resident who they identify as being at high risk for victimization to a different level than a resident who they identify as being at high risk for abusing another resident since the bedrooms are on two (2) different floors. This flexibility ensures that these residents would never share a restroom or bedroom. No resident is allowed in the bedroom or restroom of another resident so these safeguards would lower the resident's risk for being sexually assaulted.

Standard number here	115.251

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. The facility has a policy that it will accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties and promptly document any verbal reports. The facility has numerous posters throughout the house visible to all residents, staff and visitors. The facility also has this reporting information in the resident's handbooks and on their website for third parties to view. The posters, handbook, and website also contain contact information for an outside entity that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to facility officials, allowing the resident to remain anonymous upon request.

During my interviews with residents, they all knew how they could report allegations of sexual abuse or harassment and knew the person within the agency that they should contact in addition to any staff member. They all knew that they could report anonymously or that they could have a third party report their allegation for them if they did not feel comfortable doing so themselves. Additionally they each informed me of an outside agency that they could contact that they know would accept their allegation and investigate it. They also stated that at anytime they could call the police if they felt that they were in danger.

My interviews with staff members also revealed the same information. Each staff member knew that the PREA Coordinator would investigate all claims of sexual abuse and sexual harassment immediately and they knew that the residents could remain anonymous when reporting their claims and that they could have a third party report their allegation for them. While they do have a grievance form for all residents, the staff members all informed me that a resident could make his claim verbally and they would document it promptly and forward it to the PREA Coordinator immediately. When asked what they would do if a resident came to them with a claim of sexual abuse they all stated that they would keep the resident safe and call the police. Each knew that while the police department was not listed on the posters that they could call them if they feel that any resident is in danger.

When I asked each staff member what they would do if they were the victim of sexual abuse in the facility they stated that they would call the police. Additionally they knew that they could go to the PREA Coordinator, the Chief Human Resources Officer or any other member of management and they would investigate their claim immediately and privately. The Chief Human Resources Officer also verified the facility policy regarding staff members privately reporting claims of sexual abuse or sexual harassment.

Standard number here	115.252

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

Non-Applicable

While the facility has a grievance procedure to address violations of client rights, it is not used to address resident grievances regarding sexual abuse. A resident is not required to file a grievance in order to allege sexual abuse.

Standard number here	115.253

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility provides residents with outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free numbers of a local rape crisis organization. The facility further enables reasonable communication between residents and these organizations in as confidential a manner as possible.

The facility has the contact information, including a toll free number, for the Mental Health Board of Licking and Knox Counties where they can report any allegation of sexual abuse or sexual harassment anonymously. This information is also provided on the posters throughout the house, a pamphlet that the facility will give to the residents once they provide them with formal education on PREA and the resident handbook.

During the resident interview portion of the audit, the residents all informed me of an outside agency that they feel they could report any allegations of sexual abuse or sexual harassment to. They were all aware of the Mental Health Board as well. The staff members interviewed also stated that the residents could call the Mental Health Board if they wanted to report an allegation of sexual abuse or sexual harassment. When the staff members were asked by myself if they had the option to inform anyone including the PREA Coordinator if a resident alleges sexual abuse or harassment they all stated that they knew they were considered mandatory reporters and that they were required to report all allegations so that they could be investigated. I further asked these staff members if a resident wanted to inform an outside agency of their claim what they would do. They stated that they would let them do so in an office so as to protect their confidentiality with the other residents but that they would inform the resident that they are mandatory reporters so anything they say to them would be reported. They stated that if the resident asked, they would let them talk to the outside agency in private and not monitor the phone call. When I asked the residents if the staff members could keep their allegation confidential they stated that no they knew the staff members had to report it to the authorities because the Spencer House investigates all allegations. When asked how they knew this they stated that it was on the posters they had in the house and that staff had explained it to them when they asked about the posters. They also knew that they could report their claims anonymously to an outside agency if they did not want to inform staff and that their claim would be investigated by that agency.

The facility has a policy that mandates all staff members to report all allegations of sexual abuse and sexual harassment and for them to inform the residents of this if an allegation is made. The policy also states that the facility will provide residents with outside victim advocacy services for emotional support services related to sexual abuse.

The facility has entered into a Memorandum of Understanding with the Licking County Rape Crisis Center to provide residents victim advocacy services related to sexual abuse/harassment. Documentation of this MOU was provided by the PREA Coordinator at the time of the on-site audit.

Standard number here	115.254

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has an established method to receive third-party reports of sexual abuse and sexual harassment and distributes this information publicly on their website. The website informs any person who feels that they know someone in the Spencer House who is being victimized that they can report the claim of sexual abuse or sexual harassment on behalf of the resident. The website provides contact information for the third-parties to report the information to the PREA Coordinator as well as the contact information for the Mental Health Board. Toll free numbers are provided. The website further informs the third-party that they can anonymously report their claim.

Additionally, the facility provides this information on their posters throughout the facility which are also visible to visitors in common areas, on pamphlets and the resident handbook which, upon completion of the Corrective Action Plan for standard 115.233, will both be given to residents upon their intake to the facility.

The facility's policy states that staff members will accept any allegations of sexual abuse or sexual harassment made by third-parties and will forward such information to the PREA Coordinator to be investigated.

During the resident interviews, each resident informed me that they knew that someone else could make a claim on their behalf and they knew this because it was on the poster in the house. The staff members also knew that third parties could report claims of sexual abuse or sexual harassment and that they could do so anonymously.

Standard number here	115.261

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy that requires that all staff report immediately and according to policy any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility, whether or not it is part of the facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Policy also states that apart from reporting to designated supervisors or officials, staff members shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in the facility policy, to make treatment, investigation and other security and management decisions. Policy further states that unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of 115.261 and to inform residents of the practitioner's duty to report and the limitations of confidentiality, at the initiation of services.

While the facility is an all adult facility for males over the age of 18, if the alleged victim is considered a vulnerable adult under a State or local vulnerable persons statute, the facility will report the allegation to the designated State or local services agency under applicable mandatory reporting laws. The facility's policy speaks directly to this language of the standard.

Per the Program Director and the Chief Operating Officer, the Spencer House would not willingly accept a person deemed as a vulnerable adult as they are more than likely not able to provide for themselves and be self-sufficient in their own program. However, they stated that if they were court ordered to accept such a person that they would act in accordance with their policy on reporting for such a protected class.

Facility policy also states that the staff members shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's PREA Coordinator. While there have been no allegations of abuse, there was an allegation of sexual harassment as a previous staff member being the alleged perpetrator in the incident. This allegation was forwarded to the PREA Coordinator according to facility policy and proper documentation was kept in an administrative investigation file provided by the PREA Coordinator.

The staff interview portion of the audit confirmed all aspects of this policy and the staff members were well versed on their responsibilities if an allegation of sexual abuse or harassment was to be made. They all stated that they would not disclose any aspect of the allegation to anyone other than to who needed to know as per the facility policy. When I asked them what they would do if a resident came to them during their shift with an allegation of sexual abuse they all immediately stated that they would call the police. They would further inform their supervisor as well as the PREA Coordinator but they informed me that their first priority would be to provide for the safety of the resident, the other residents, and the staff members in the house at the time. During the interview with one of the Licensed Professional Counselors he informed me that if any resident were to come to him with an allegation of sexual abuse or sexual harassment he would inform him of his duty to report this allegation before they decided to proceed with telling him the allegation.

Standard number here	115.262

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy that states when their agency learns that a resident is subject to a substantial risk of imminent sexual abuse, staff shall take immediate action to protect the resident. Policy further states that the staff shall consider housing changes or transfers for resident victims or abusers out of their facility and back into the agency that sentenced them, removal of the alleged staff or resident abusers from contact with the victims and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

I asked each staff member who I interviewed what they would do if they learned that a resident was subject to a substantial risk of imminent sexual abuse and they all stated that they would first ensure that resident's safety was protected by moving them wherever necessary that would provide them with the most security until the Newark Police Department arrived. They also stated that they would ensure the victim and abuser stay separated until the police arrived. They stated that they would call the PREA Coordinator so that she could come to the facility to conduct an investigation and they would call their supervisor if anyone needed removed from the facility.

I asked each resident during the interview portion if they felt an overall sense of safety and security at the Spencer House and they all responded without a doubt that they feel safe and they know that the staff members would always ensure their safety if it was in question. I asked them if they felt comfortable going to staff if they felt they were in danger and they stated that although they feel comfortable going to any staff member, if they for some reason felt that they could not they could get on their resident phones and call the police if they felt their safety was in immediate danger.

During the past 12 months, no resident was deemed to be subject to substantial risk of imminent sexual abuse. The Chief Operating Officer as well as the Program Director informed me that they have the authority to terminate any resident from their facility and they do not need to have court approval. If a situation arose that put any resident at risk for imminent sexual abuse they have the authority to terminate the alleged perpetrator in order to ensure everyone else's safety.

Standard number here	115.263

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy that states, upon receiving an allegation that a resident was sexually abused while confined at another facility, the PREA Coordinator or Vice President and Chief Operating Officer shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The policy further states that the PREA Coordinator or the Chief Operating Officer shall document that they have provided such notification. Additionally, if the facility receives an allegation that an ex-resident was sexually abused while confined at the Spencer House that the PREA Coordinator will conduct an investigation into such a claim in accordance with the reporting policy.

During the staff interviews with the PREA Coordinator and the Chief Operating Officer as well as the Program Director they each stated that they would determine among the three (3) of them who will be

calling the other confinement facility and then document that they did so. They each knew that the notification to the other facility needed to be within 72 hours of receiving the allegation. When asked what they would do if another confinement facility informed them that an ex-resident was sexually abused while at the Spencer House they each stated that they would treat it like a third-party report and conduct an administrative investigation into the matter and if it contained criminal content refer it to the Newark Police Department for criminal investigation.

The facility has received zero (0) allegations of abuse from residents that they were abused while confined at another facility within the past 12 months. They also have received no reports of abuse from other confinement facilities about ex-residents of the Spencer House.

Standard number here	115.264

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy that contains detailed instructions for every staff member involved when an allegation of sexual abuse is made. This policy is effective whether the first responder is a security staff member or any other type of staff member. The policy states that the first responder will perform the following duties:

1. Separate the alleged victim and abuser;
2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
3. If the abuse occurred within a time period that still allows for the collection of physical evidence, 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;
4. If the abuse occurred within a time period that still allows for the collection of physical evidence, 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.

The facility has had no reports of sexual abuse within the past 12 months, therefore, there was no documentation to review to determine if this policy had been followed.

The staff members interviewed all were aware of their duties regarding being a first responder. Staff members interviewed included security staff, treatment staff and administration/management staff. Each staff member clearly stated that they would first separate the alleged abuser and victim and ensure for the victim's and abuser's medical needs first and foremost which included calling 911 for an ambulance. They stated that they would call the Newark Police Department in order to start a criminal investigation into the matter. They would secure the crime scene and any usable evidence for the Newark Police upon their arrival. I asked each of them specifically if they would allow the victim or abuser to wash themselves, brush their teeth, change their clothing, urinate, defecate, smoke, drink or eat and they all emphatically said no that it would destroy evidence.

Standard number here	115.265

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators and facility leadership.

The facility's coordinated response plan is very detailed and contains definitions of sexual abuse and sexual harassment. It contains the facility's preventative measures that are taken to ensure that sexual abuse or sexual harassment does not take place in their facility. Such measures include their detailed screening instrument given to all residents to assess their risk of victimization or abuse. The plan also includes specific instructions for how the staff member who is the first responder should handle a report of sexual abuse. It specifically requires them to follow the requirements of 115.264 regarding first responder duties. Further it contains information for what the PREA Coordinator, Program Director, Victim Support Person and Counselors should do following the report of sexual abuse. This plan follows the victim/abuser through their stay at the facility and ensures for individualized treatment. It contains the rights of the residents to be treated for no charge and what services they are to receive following an allegation of sexual abuse. It also contains information for how the victim/abuser shall be ensured continuity of care upon their release from the facility.

Standard number here	115.266

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

Non-Applicable

Neither the Spencer House or Behavioral Health Partners has a union for it's staff members, therefore, no contracts are entered into regarding collective bargaining agreements.

Standard number here	115.267

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has 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 and designates the residential staff members of the Spencer House with monitoring retaliation. Additionally during staff interviews, the Program Director explained how she is involved with the day to day operations of the house and she will also be monitoring retaliation. The PREA Coordinator also acknowledged that in addition to the residential staff she will ensure the monitoring of retaliation since she is the one conducting the investigations into such. All of the upper level staff members stated that they would designate themselves in addition to the policy mandated residential staff to monitor retaliation so they could ensure no retaliation takes place.

The policy states that the facility will 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. For at least 90 days following a report of sexual abuse, the facility will monitor the conduct and treatment of residents or staff who reported the sexual abuse and 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, and shall act promptly to remedy any such retaliation. The policy states that staff shall monitor resident disciplinary reports, housing, or program changes, negative performance reviews or reassignments of staff and in the case of residents, periodic status checks. The facility will continue this monitoring beyond 90 days if the initial monitoring indicates a continuing need. This policy also provides multiple protection measures to individuals who cooperate with an investigation who express a fear of retaliation. Once the allegation is determined to be unfounded, the facility's obligation to monitor will terminate.

Standard number here	115.271

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy to investigate all allegations of sexual abuse and sexual harassment. The PREA Coordinator conducts an administrative investigation into all allegations and refers any allegations with criminal components to the Newark Police Department for Criminal Investigation. The facility has a policy that states that they will conduct administrative investigations into allegations of sexual abuse and sexual harassment promptly, thoroughly and objectively for all allegations including third party and anonymous reports. The PREA Coordinator has received extensive training regarding the conduct of sexual abuse investigations pursuant to 115.234. The facility has a Memorandum of Understanding with the Newark Police Department that states they will conduct their investigations in accordance with the PREA Standards. The Newark Police Department will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data. They will interview alleged victims, suspected perpetrators, and witnesses and will review prior complaints and reports of sexual abuse involving the suspected perpetrator. If the quality of evidence appears to support criminal prosecuting, the Newark Police Department will conduct compelled

interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

The facility's policy ensures that the credibility of the alleged victim, suspect, or witness will be assessed on an individual basis and will not be determined by the person's status as a resident or staff member. The facility does not require a resident to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. The PREA Coordinator will, in the conduct of her administrative investigation, include an effort to determine whether staff's actions or failures to act contributed to the abuse. She will then document in the written administrative report that includes a description of the physical and testimonial evidence, the reasoning behind the credibility assessments and investigative facts and findings. The criminal investigations will be documented in a written report from the Newark Police Department containing a thorough description of physical, testimonial and documentary evidence and include attached copies of all documentary evidence where feasible. The PREA Coordinator will serve as the liaison between the facility and the Newark Police Department and will cooperate with all outside investigations and will remain informed about the progress of the investigation. All substantiated allegations of conduct that appear to be criminal will be referred for prosecution. The facility will retain all administrative and criminal investigation reports for as long as the alleged abuser is incarcerated or employed by the facility, plus five (5) years. The departure of the alleged abuser or victim from the employment or control of the facility will not provide a basis for terminating an investigation.

In addition to facility policy, interviews with the PREA Coordinator, the Chief Human Resources Officer, the Program Director and the Memorandum of Understanding with the Newark Police Department were used for documentation of this standard. The facility has had no allegations of sexual abuse during the past 12 months, therefore, there was no documentation to review. The facility has had one allegation of sexual harassment within the past 12 months. I reviewed the administrative investigation into this allegation. The allegation was determined to be unsubstantiated and the facility followed all policies and procedures regarding conducting an administrative investigation.

(k)

Non-applicable

The Spencer House is not a state entity or Department of Justice component.

Standard number here	115.272

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy that states that they will impose no standard higher than the preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The PREA Coordinator confirmed this policy during her interview as well as was evidenced in her administrative investigation into the sexual harassment claim against a former staff member. She explained to me how she reached her unsubstantiated decision and documentation supported such a decision and further substantiated the no standard higher than a preponderance of the evidence in determining whether the claim was substantiated or unsubstantiated.

Standard number here	115.273

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in the facility is informed verbally or in writing as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded following an investigation by the facility. The facility will also request the relevant information from the Newark Police Department in order to inform the resident of the outcome of the investigation. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility wil subsequently inform the resident (unless the facility has determined that the allegation is unfounded) whenever;

1. The staff member is no longer posted within the resident's house
2. The staff member is no longer employed by Behavioral Healthcare Partners
3. The facility learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
4. The facility learns that the staff member has been convicted on a charge related to sexual abuse within the facility

Following a resident's allegation that he or she has been sexually abused by another resident, the facility will subsequently inform the alleged victim whenever:

1. The facility learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
2. The facility learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility

The policy states that all such notifications or attempted notifications will be documented and their obligation to report under this standard will terminate if the resident is released from the facility.

The facility has had no allegations of sexual abuse within the past 12 months so there was no documentation to review. The PREA Coordinator was very aware of the details in the policy and is aware of the facility's duty to report to residents following an allegation of sexual abuse suffered in their facility.

Standard number here	115.276

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy stating that staff members are subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies. Termination is also the presumptive disciplinary action for staff who have engaged in sexual abuse. Disciplinary sanctions for violations of facility 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 for comparable offenses by other staff with similar histories. Policy also states that 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, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to the relevant licensing bodies.

The facility has had no reports of sexual abuse within the past 12 months, however they did have a claim of sexual harassment. The claim was investigated according to facility policy and the staff member had resigned his position prior to the allegation being made and the investigation being conducted. When I asked the PREA Coordinator what she would have done regarding sanctioning this employee if the claim were found to be substantiated she answered according to the standards and facility policy regarding staff disciplinary sanctions. The activity in this claim was clearly not criminal, therefore, reporting to licensing bodies or law enforcement agencies was not necessary.

Standard number here	115.277

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility policy regarding staff disciplinary sanctions for violating agency policy on sexual abuse or sexual harassment includes contractors and volunteers. Any contractor or volunteer who engages in sexual abuse is prohibited from contact with residents and will be reported to law enforcement agencies, unless the activity clearly was not criminal, and to relevant licensing bodies. The facility will also take remedial measures and shall 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 or volunteer.

During my interview with the PREA Coordinator she was very aware of the policy on staff sanctions for engaging in sexual abuse or sexual harassment and stated that without a doubt it applies to contractors and volunteers as well. I also interviewed a volunteer who stated that she would expect for the facility to sanction staff for engaging in sexual abuse and sexual harassment and she would expect nothing less so as to ensure the safety of all of the residents. I asked the Chief Human Resources Officer and the Chief Operating Officer what they would do if a volunteer or contractor were alleged to have committed

sexual abuse or sexual harassment and they both stated that they would prevent the volunteer or contractor from returning to the facility until a full investigation was conducted and would follow the policy regarding sanctioning the volunteer or contractor.

Standard number here	115.278

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy regarding disciplinary sanctions for residents. Residents are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. The policy states that sanctions will be 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. The disciplinary process will consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The facility will discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

The facility also offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse. Policy further states that the facility will consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The facility has a policy prohibiting all sexual activity between residents and will discipline residents for such activity. The facility will not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

Within the past 12 months, there was only one claim of sexual harassment made against a staff member. The resident alleging the claim was not disciplined for bringing forth the claim although she refused to participate in the investigation upon her release from the facility. Additionally, another resident was interviewed during the investigation and did not wish to participate in the investigation. She was not punished either for wishing to not participate in the investigation. The PREA Coordinator walked me through her investigation step by step and although the claim was deemed to be unsubstantiated she followed all steps of the investigation policy and policies on staff sanctions and resident sanctions. Both residents involved in the investigation did not wish to participate upon their release, the staff member in question had resigned his position prior to the allegation and the resident in question was successfully released from the facility prior to the allegation. The resident in question denied any improper contact between the staff member and herself and stated that he always treated her professionally. The staff member who resigned did not return the PREA Coordinator's call so he was not involved in the investigation.

During my interviews with the Program Director and the Chief Operating Officer they both assured me that they would offer counseling services and other interventions designed to address and correct underlying reasons or motivations for abuse as they are there to help the residents become better at solving problems in their life without hurting themselves or others. With all of the services that Behavioral Healthcare Partners offers, it is very clear that the facility would do whatever it takes to help the residents with these issues succeed.

Standard number here	115.282

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy addressing access to emergency medical and mental health services. The policy states that resident victims of sexual abuse will 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. Additionally, resident victims of sexual abuse will be 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. These treatment services will be provided to the victim at no financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. If a report of abuse is made when no qualified mental health practitioners are on duty, the first responders will take preliminary steps to protect the victim pursuant to 115.262 and will immediately notify the appropriate medical and mental health practitioners.

The facility does not employ medical health practitioners, however, they do employ mental health practitioners. During my interview with a clinical counselor, he informed me of the treatment services that the residents would receive while in residency if they were a victim of sexual abuse. He also assured me that they would refer the resident for continuing treatment if necessary upon their release from the Spencer House. Interviews with potential staff first responders also confirmed the treatment services that are available to residents.

Standard number here	115.283

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility will 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. The evaluation and treatment of such victims will 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. The facility will also provide such victims with medical and mental health services that are consistent with the community level of care. They will be provided tests for sexually transmitted infections as medically appropriate. These treatment services will 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 also states that it 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 by mental health practitioners.

The screening instrument the facility uses is very detailed and contains numerous questions regarding the resident's mental health status and history. No resident has claimed to have been a victim of sexual abuse while incarcerated in another facility, therefore, no documentation was available for review. Each resident interviewed, however, all stated that they felt comfortable enough with their counselors that they would report such abuse to the facility.

(d) (e)

Non-Applicable

All residents of the Spencer House are adult males, therefore, would not require pregnancy services.

Standard number here	115.286

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

The facility has a policy that it 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. This review will ordinarily occur within 30 days of the conclusion of the investigation. The review team consists of upper-level management staff members, with input from line staff supervisors, investigations, and medical or mental health practitioners.

The policy states that the review team will:

1. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
2. 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;
3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
4. Assess the adequacy of staffing levels in that area during different shifts;
5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and

6. Preapare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA Coordinator.

The facility will implement the recommendations for improvement, or will document its reasons for not doing so.

My interview with the PREA Coordinator confirmed that all aspects of this standard were completed during their staff review of the sexual harassment allegation claim against a former staff member. Although, there were no allegations of sexual abuse at this facility within the past 12 months, the facility did conduct a review of the incident of the sexual harassment claim against a former staff member. From that allegation, the decision was made to request a grant for more video surveillance. The review team consisted of upper-level management staff and also involved were the residential staff so they could explain from their view point which areas of the facility they would consider to be blind spots and needing more attention. The interviews with the staff members confirmed that they are involved in a lot of decisions that upper level management makes and they feel that their input is given great consideration as they have seen changes made because of their input.

The upper level management of this facility seems to take the safety of the residents and staff members very seriously and is constantly looking for ways to improve the safety and security of their facility. The Program Director is heavily involved in the day to day operations and all staff interviewed stated that they feel very comfortable coming to her if they are having any problem or feel that any issue needs addressed in their facility.

Standard number here	115.287

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

Non-Applicable

The Spencer House is not an agency responsible for facilities under it's direct control.

Standard number here	115.288

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

Non-Applicable

The Spencer House is not an agency responsible for facilities under it's direct control.

Standard number here	115.289

☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard

Non-Applicable

The Spencer House is not an agency responsible for facilities under it's direct control.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

Jennifer Renee Morgenstern — February 9, 2015

Auditor Signature — Date