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

☐ **Interim** ☒ **Final**

Date of Interim Report: March 27, 2020

Date of Report Final Report July 27, 2020

Auditor Information

Name: Susan Jones	**Email:** sjjcanoncity@gmail.com
Company Name: Susan Jones CJ consulting	
Mailing Address: Box 1773	**City, State, Zip:** Canon City, CO 81215
Telephone: Click or tap here to enter text.	**Date of Facility Visit:** February 12 – 14, 2021

Agency Information

Name of Agency: Advantage Treatment, Alamosa Colorado		**Governing Authority or Parent Agency** *(If Applicable)*: N/A	
Physical Address: 2017 Lava lane		**City, State, Zip:** Alamosa, Colorado 81101	
Mailing Address: 2017 Lava Lane		**City, State, Zip:** Alamosa, Colorado 81101	
The Agency Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

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

Agency Chief Executive Officer

Name: **Doug Carrigan - President**	
Email: **doug.carrigan@advantage-tx.com**	**Telephone:** **303-591-3303**

Agency-Wide PREA Coordinator

Name: Kristie Garcia	
Email: **Kristie.garcia@advantage-tx.com**	**Telephone:** **970-571-3983**
PREA Coordinator Reports to: **Josh Mayhugh – Vice President**	**Number of Compliance Managers who report to the PREA Coordinator:** 4

Facility Information

Name of Facility: **Advantage Treatment Centers, Inc**

Physical Address: 2017 Lava Lane	**City, State, Zip:** Alamosa, Colorado 81101
Mailing Address (if different from above): Click or tap here to enter text.	**City, State, Zip:** Click or tap here to enter text.

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

Facility Website with PREA Information: **www.advantage-tx.com**

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

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

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
Core Security Audit- Department of Criminal Justice April 2019

Facility Director

Name: Glen Hodges

Email: **glen.hodges@advantage-tx.com**	**Telephone:** **719-589-7511**

Facility PREA Compliance Manager

Name: Glen Hodges

Email: glen.hodges@advatage-tx.com	**Telephone:** 719-589-7511

Facility Health Service Administrator ☒ N/A

Name: Click or tap here to enter text.

Email: Click or tap here to enter text.	**Telephone:** Click or tap here to enter text.

Facility Characteristics

Designated Facility Capacity:	140
Current Population of Facility:	118
Average daily population for the past 12 months:	71.11
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	18+
Average length of stay or time under supervision	106.4 days
Facility security levels/resident custody levels	Minimum/community

Number of residents admitted to facility during the past 12 months	223
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	216
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	149
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☒ Yes ☐ No

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

Number of staff currently employed by the facility who may have contact with residents:	43
Number of staff hired by the facility during the past 12 months who may have contact with residents:	23
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	4

Number of individual contractors who have contact with residents, currently authorized to enter the facility:	4
Number of volunteers who have contact with residents, currently authorized to enter the facility:	2
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the Auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	3 (residential facility, treatment facility and the Kitchen)
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	4
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	49
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☐ Yes ☒ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: Parole in some cases) ☐ N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	2
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☒ Facility investigators ☐ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☒ N/A

Audit Findings

Audit Narrative

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

This facility, Advantage Treatment Center/Alamosa is one of four facilities operated in Colorado by Advantage Treatment Centers.

The notice of the audit was provided to the facility by the Auditor and posted at the facility on 12-24-2019. These notices were observed in several places during the on-site audit process. This audit was not conducted through the on-line audit system, consequently, the facility provided information to the Auditor electronically. The documents provided in advance included policy that addressed each of the standards, client handbook, staffing matrix, training curriculum, screening tools, client intake packet, Core Security Audit- Department of Criminal Justice April 2019, and the previous PREA audit report completed in November 2015.

The Auditor arrived on-site in Alamosa on February 12, 2020 and completed the on-site portion on February 14, 2020. The Auditor spent 21.5 hours on-site in Alamosa, including time on day shift, afternoon shift, and overnight shift. This allowed for ease of access to both on-duty staff and clients who were available at differing times due to treatment, work, and social obligations.

During the on-site audit process, clients, staff, contract staff, and volunteers were interviewed using the interview templates provided for PREA audits of Community Confinement facilities. Clients were selected based upon on characteristics that matched those required for interview as well as clients who were randomly selected by the Auditor. Random selection was accomplished by the Auditor randomly circling names on the active client roster for the day.

Clients	Number
Physical Disability	3
Blind, Deaf, or Hard of Hearing	1
Limited English Proficiency	0
Cognitive Disability	1
Identify as Lesbian, Gay, or Bi-Sexual	3
Clients who identify as Transgender or Intersex	0
Clients who reported Sexual Abuse	0
Clients who reported Sexual Victimization during Risk Screening	8

Total Targeted Interviews (some clients were included in more than one targeted category)	13
Clients interviewed – Male	11
Clients interviewed – Female	14
Random Client interviews	12
Total Client Interviews	25

Most of the staff who were on-duty during the on-site audit were interviewed by the Auditor. Due the low number of staff employed at this facility, there was no need for a random selection. All staff at this facility are considered first responders for a PREA incident, therefore, all staff interviews included a portion of targeted interviewing and random interview questions. A recurrent theme in these interviews was the high level of care and concern that the employees conveyed for their clients and for the work that they do.

The interviews for the Agency Head and PREA Agency-aide Coordinator were conducted via phone as each of these individuals are officed in another area of the state. The interviews of the four-contract staff were also conducted via phone as they were not scheduled during the audit. Each of these contract staff work with the treatment program as clinicians/group facilitators. The only two volunteers who provide services at this facility were also interviewed during the on-site audit.

Staff	Admin Shift	Graveyard Shift	Day Shift	Swing Shift
Intake				1
First Responder	7	2	5	7
Transport	2			
Investigator	2			
Bed Assignment	1			
PREA coordinator	1			
Agency Head	1			
Facility Director	1			
Human Resources	1			
Contract Staff	4(phone)			
Food Service			1	1
Total Staff interviewed	37			

Volunteer Staff	2			

A tour of the facility was conducted and all areas of the facility were inspected, with particular concern to the areas where clients have access. Additionally, documents reviewed included: staff training records, staff employment records, client files (both paper and electronic), intake process records, client handbooks, grievances, PREA incident tracking document, disciplinary action reports, posters hanging in the facility, and other notices posted in a variety of locations.

The Auditor contacted each of the outreach agencies/phone numbers provided to clients to call to report a PREA incident or concern. Additionally, the Auditor was able to interview staff in person at the local crisis center, Tu Casa of Alamosa. This agency's mission includes: providing crisis intervention, shelter services, and advocacy to victims and survivors of domestic and sexual violence.

During the pre-audit phase, the on-site audit, and post audit process, modifications were made to policy documents, processes, and training. These actions will be noted in each standard explanation section.

During the Post-audit phase, the Auditor worked with the PREA coordinator and the Facility Director to makes necessary changes to processes, training, and policy. The specifics of each of these actions is notated in the applicable standard language.

The only barrier to completion of this audit occurred after the on-site portion was completed. The pandemic, COVID-19, delayed some actions from the agency that would have moved one or most standards complaint by the publication date of the interim report.

As a result of COVID-19 restrictions, the Auditor did not return to the facility, as planned, to follow up on the issues of non-compliance. Instead, a plan was developed between the PREA coordinator, the Facility Director and Auditor, to ensure compliance with the issues identified in the initial report. The Auditor was able to review documents (electronically), interview clients through a "zoom" conference and interview randomly selected staff via phone conversations.

During July 2020, the Auditor interviewed 9 clients and spoke to 25 staff members. The clients interviewed included both male and female and included both clients in the community corrections program as well as the Intensive Residential Treatment (IRT) program.

The staff interviewed included full-time staff and contract staff. The staff who were interviewed were on all three shifts, included treatment staff, case managers, kitchen employees, and client managers. Some of these staff were randomly selected by the Auditor who called to at different times to talk to on-duty staff. Others were selected by the Auditor based upon their job titles. The Auditor also spoke to two contract treatment employees. Not volunteers were

contacted because there are no volunteers approved to enter the facility (due to COVID-19 restrictions).

The Auditor finds that all areas of non-compliance have been addressed and the Advantage Treatment Center-Alamosa is in full compliance with the PREA standards for community confinement facilities.

Facility Characteristics

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

This facility is located at 2225 Lave Lane, Alamosa, Colorado, near the southern edge of the town. The facility consists of three separate buildings that are adjacent to each other: The main facility includes three housing units (male community corrections, female community corrections, and male treatment) and the security office, the treatment building that includes housing for female clients who are in the treatment program, and the kitchen/dining room. The facility has several outdoor recreation areas for use by clients.

The housing units include a variety of different room/bathroom facilities, that include 2,4, and 8 person rooms. There are some rooms with bathroom located within them for use by the clients who are assigned to that room. The majority of clients use a bathroom/shower room that is located in the area near to their assigned bedrooms. The bathrooms have stalls surrounding toilets and most have at least one urinal. The urinals do not have stalls surrounding them, but they are located within the bathroom and are adjacent to a stall on one side and a wall on the other. In addition, there is a door leading from the bathrooms to the hallways. In many locations individual showers are equipped with curtains that are adequate to allow for privacy in dressing and showering. In other areas, there are showers with four shower heads to an area. These showers have a curtain that prevents those outside the shower area from observing clients who are using the showers. There are two bathrooms that are located in other areas of the facility. One of these bathroom/shower rooms is equipped to allow a disabled person to use the facilities safely.

Clients are expected to change clothing only in the bathrooms or in their assigned rooms. All clients are expected to be fully dressed in the dayrooms, hallways, and other areas of the facility.

The food service building includes a kitchen area and a dining room. This area is staffed by at least one employee and occasionally up to 2 clients are assigned to help in the preparation, service, and clean-up of that area.

The facility is equipped with 98 cameras and the facility is in the process of upgrading this camera system. None of these cameras are positioned in a bedroom or bathroom/shower area.

The facility houses clients from court referrals, Colorado Department of Corrections, and occasionally accepts clients from the City of Alamosa. There are both male and female clients housed in this facility. These clients are considered community/minimum security level offenders and all clients are over the age of 18. The capacity for the facility includes space for 60 female and 80 males. On the first day of the audit, there were 118 clients and of this total, 48 clients were assigned to the Intensive Residential Treatment program (24 females/24 males).

The Residential Treatment program provides a 90-day treatment program to clients who have a history of substance use. The program primarily utilizes cognitive behavioral interventions, with a wide array of treatment modalities including intensive case management, life skills sessions, group and individual therapy, peer-lead services and activities, as well as evidenced based curriculums including Moral Reconation Therapy (MRT), Seeking Safety, and Strategies for Self-Improvement and Change. The program focuses on recovery from substances as well as criminal conduct.

The staffing plan for this facility requires at least three client managers (security/housing) positions on-duty at all times. One client manager is assigned to the treatment/female housing area and the other two are assigned to the main part of the building. The security office must be staffed by at least one person at all times.

Summary of Audit Findings

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

Not applicable -

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

Standards Exceeded

Number of Standards Exceeded: 1
List of Standards Exceeded: 115-215

Standards Met

Number of Standards Met: 38

Standards Not Met

Number of Standards Not Met: 0

Click or tap here to enter text.

The following standards were not met at the time of the interim report, dated March 2, 2020. During the corrective action process these standards were found to be in compliance.

115.215 Limits to cross-gender viewing and searches
115.221 Evidence protocol and forensic medical examinations
115.222 Policies to ensure referrals of allegations for investigations
115.231 Employee training
115.232 Volunteer and contractor training
115.233 Resident education
115.235 Specialized training: Medical and mental health care:
115.241 Screening for risk of victimization and abusiveness
115.242 Use of screening information
115.251 Resident reporting
115.261 Staff and agency reporting duties
115.271 Criminal and administrative agency investigations

The following standards were found compliant, based upon the fact that they were not applicable to this agency:

115.212 Contracting with other entities for the confinement of residents
115.234 Specialized training: Investigations
115.252 Exhaustion of administrative remedies
115.266 Preservation of ability to protect residents from contact with abusers

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.211 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The Advantage Treatment Centers have created and published a policy that communicates a zero-tolerance of all forms of sexual abuse and sexual harassment. This policy outlines the agency's approach to prevention, detection and response to any type of sexual abuse or sexual harassment.

The agency has designated an agency wide PREA coordinator who is in the upper-level of the agency. The PREA compliance manager duties are being handled by the Facility Director. The agency wide PREA coordinator has ample time and authority to complete the duties associated with the requirements of the standards.

Corrective Action completed: Not all of the elements of the PREA standards that needed to be in policy were present at the beginning of the on-site audit process. Several revisions to policy were made during and after the on-site audit. The policy is now clear and contains the necessary elements.

Data Relied upon: Policy review, interviews of staff and clients, and observations during tours to ensure compliance with the standard.

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

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

115.212 (a)

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

115.212 (b)

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

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This agency does not contract with other entities to confine their clients.
This standard is compliant because it does not occur in this agency.

Data Relied upon: Policy review, interviews with the Agency head and the PREA coordinator, and observation of movement/control logs.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

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

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

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The facility has a documented staffing plan that indicates the necessary levels of staffing. This plan has been developed by taking into consideration the physical layout of the facility, the video monitoring capability of cameras, and the type of numbers of allegations of sexual harassment and sexual abuse.

This staffing plan indicates the post title, scheduled days and shift for each area of the facility. Additional documentation includes the numbers, titles, and shift of staff who work in non-relievable posts, such as case management and program positions.

The plan has been adjusted in the past year to accommodate the fluctuating client population and corresponding need for staff. The use of contract treatment staff has also allowed the facility to maintain a fully staffed treatment program, even when regularly assigned staff are on leave.

Corrective Action completed: The Facility Director was able to explain the construction of the staffing plan but there was no written explanation. During the on-site audit, the director was able to document and justify the construction of the plan. The facility had a process to allow for deviations of the staffing plan, based upon staff vacancies and unexpected workload issues. This process was not formally documented prior to the on-site audit. This documentation is now included in the tracking system created by the Facility Director. The Facility Director provided documentation for four-weeks of deviations from the plan, after the on-site audit.

Data Relied upon: Review of staffing plan and supporting documents, interviews of staff, observations during the on-site audit, and comparison of the schedule for staff and the staff on-duty.

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

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

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

115.215 (c)

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

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

115.215 (d)

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

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

115.215 (e)

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

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

115.215 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the Auditor's analysis and reasoning, and the Auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility does not allow for strip searches or visual body cavity searches of clients for any purpose. The facility's policy does not allow for cross gender pat searches and no such pat searches were observed while the Auditor was on-site.

Adequate staffing exists to allow female and male clients access to programming, work within the community, and other types of social/leisure activities.

The design of the facility allows for clients to shower, dress, and perform bodily functions with many options for privacy from staff and other clients. The facility has rooms with 2, 4, or 8 individuals assigned. These rooms have solid doors. Additionally, many of the bathrooms have doors and stall partitions. The shower areas have curtains that allow for privacy. All staff knock to announce their presence on bedroom and bathroom doors. They then wait for a verbal response, if any, prior to opening the door.

During the past year (October 2019), there was a group of grievances (9) filed by female community corrections clients who were complaining about staff not knocking, prior to entry. These grievances revolved around an incident where a female client was found in her room using drugs. In this case, the staff were aware of this possibility and a decision was made to enter the area with announcing their presence. They did so, and in fact, found the client in possession of drugs. The Facility Director then met with the group of female clients who had filed grievances and those who were concerned about this issue to explain the deviation from policy. This community meeting appeared to have resolved the concerns of clients. During client interviews I asked if they were able to change clothes, perform bodily functions, and shower without staff of the opposite gender viewing them. No client expressed a concern about this issue and no client even referred to the issue in October 2019.

Corrective Action completed:

All components of this standard have been addressed in policy and/or training curriculums. The facility does not have any clients who identify as transgender, nor have they had transgender clients in the past. After the on-site audit, the facility added to the PREA training curriculum information to cover searching transgender clients and a section that deals with housing placement The policy was updated to include the fact that searches will not be done to determine

genital status and the criteria needed to effect the most appropriate housing placement. All staff, and contractors attended the new training that covered the search procedure and policy language. The Auditor conducted follow up phone interviews with staff and contractors in July 2020 to ascertain the level of knowledge concerning this policy change.

During the on-site inspection, one door was found to be missing from a group bathroom in the female community corrections area. No one complained, or even mentioned this as an issue, but the agency replaced this door to allow for an added level or privacy. (It should be noted that the same type of bathroom set up is present in other areas of the facility, but due to the privacy barriers that had been put in place with stalls and shower curtains, all of these doors were propped open.) The new door to female restroom was installed on 3/2/2020.

Data Relied upon: Policy review, interviews of staff and clients, observations during tours to ensure compliance with the standard and follow up phone interviews conducted in July 2020 with staff and contractors.

This facility EXCEEDS the standard requirements, specifically: no cross gender pat searches are conducted, no strip searches are conducted, and the method to alert clients that cross gender staff are entering their living areas includes announcement and knocking prior to entry.

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This agency has an interpreter service available for use if needed (Cesco Linguistic Services). This service is accessible by contacting the Facility Director or the PREA coordinator. The Auditor called this number to confirm accuracy and accessibility (the call was placed on a Saturday). This service includes immediate over the phone service and the potential to arrange for an on-site interpreter.

The facility has many staff who are fluent in Spanish and no staff or residents can recall a time when any other type of language/translator was needed. Staff have not dealt with anyone who needed services to communicate with ASL. Staff have helped clients with limited English or lower cognitive functioning understand the policies of the agency by reading the material or taking additional time to explain the material to these individuals. No written materials have been translated into any other language, but it is clear that if that type of translation would be needed, the service is available to help with that translation.

During the on-site audit, the Auditor talked to clients who had hearing loss, psychiatric conditions, physical disability (including limited mobility), and limited

cognitive abilities. As a result of these conversations and physical inspection of the facility, the Auditor found no issues that created a barrier to these individuals participating fully in their programming, understanding the PREA policies, and engaging in social activities.

There was no evidence that other clients were ever asked to assist in translating for another client.

During the on-site audit, the Auditor observed a group of visitors who approached the security office for assistance. These visitors needed translation (Spanish), and on-duty staff were available and they quickly and effectively communicated with them.

Corrective Action completed: After the on-site audit, the agency distributed information to appropriate staff regarding the procedure for contacting the contracted service provider to access interpretive services.

Data Relied upon: Interview (via phone), with the interpreter services, interviews of staff and clients, and observations during on-site audit to ensure compliance with the standard.

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed personnel files of seven randomly selected staff members and the file of one new employee who began employment during the on-site audit.

No policy, or other documentation was available during the pre-audit or the on-site audit phase that addressed this standard. Interviews with HR staff indicated that the requirements of this standard are being completed and reviewed documentation confirmed these statements.

Corrective Action completed: Modification was made to policy after the on-site audit. The policy is fully compliant. Additionally, a hiring protocol for HR staff use has been updated to accurately reflect this information.

Data Relied upon: Review of personnel records, interview with Human Resources staff and review of policy and hiring protocol.

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has replaced a few cameras during the past year and one camera placement was altered to ensure safety, including sexual safety of clients. This particular camera as repositioned to ensure total coverage of an area that allows female clients to smoke in an outside secure location. This location was not under the supervision of other cameras and has no outside access.

The agency is in the process of installing a new camera system which was expected to begin in March 2020, (this installation has been delayed due to COVID-19 restrictions). This system replaces the current system and the type of equipment and placement of units was confirmed after consideration of the agency's duty to protect clients form sexual abuse.

No modifications, substantial expansion, or a new facility has been added to this location.

Data Relied upon: Interviews of staff, interview with the Facility Director and investigator, observations during tours to ensure compliance with the standard, and review of planning documentation for the new camera system.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

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

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

115.221 (e)

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

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a)

through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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This agency does not conduct investigations of sexual abuse. This function is conducted by the local police department and may be conducted by the parole authority if a transition client is involved.

Access to medical examinations by a Sexual Assault Nurse Examiner (SANE) is provided through the Convenient Care Community Clinic: Valley-Wide Health Systems, Inc. Examiners are available Monday-Saturday from 7 a.m. – 7 p.m. and on Sunday from 7 a.m. – 5 p.m. If an examination needs to be conducted outside of these hours, the client would be transported to Parkview Hospital in Pueblo, Colorado. Parkview has a 24-hour SANE program and the Pueblo Rape Crisis Center provides support for individuals during the exam (according to a phone interview with the Pueblo Rape Crisis Center). As a result, SANE exams will always be available.

A memo from VP of operations, dated Feb 11, 2020, indicates that the cost will not be the responsibility of the client. The memo includes information that indicates the agency will attempt to get these costs covered by grants or other options and provides direction to the agency directors regarding where to send any type of bill for services.

A written MOU (Memorandum of Understanding) is in place for services for emotional support and assistance from Tu Casa, the rape crisis center. This MOU ensures that emotional support will be available to clients who are undergoing a SANE examine and Tu Casa will provide a victim advocate, when needed, to clients at this facility.

The agency has documented their efforts to formulate a written agreement and this process should be finalized. The COVID-19 process has negatively affected the ability of the facility and the community organization to complete the agreement.

During the corrective action period, the agency produced evidence that they have asked the investigating agency (Alamosa PD) to follow the requirements of this standard.

Data Relied upon: Review of signed MOU, interviews with Facility Director and Investigator, interview with staff from Tu Casa, Inc (local rape crisis center), documentation from the agency that explains that costs will not be the responsibility of the client and the memo from the facility to the Alamosa PD requesting that they follow this standard's requirements.

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

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

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy is clear and practice is in support of policy, that all allegations of sexual harassment and sexual abuse are referred to an administrative and/or criminal investigation. The tracking system that has been implemented is thorough and effective in maintaining documentation and keeping track of deadlines and responsibilities. During interviews with staff, I asked about any type of PREA incident that had occurred. Each time I was able to match the description that the staff provided to the PREA tracking form.

Corrective Action taken: This standard was not adequately addressed prior to the on-site audit. The agency took corrective action to enter into an MOU with the

Alamosa Police Department to conduct criminal investigations for any incident of suspected sexual abuse. This MOU details the responsibility of both parties, including the need for appropriately trained investigators, evidence collection, documentation, and referral for prosecution.

During the corrective action period, the revised and complaint version of the PREA policy was placed on the agency website.

Data Relied upon: Policy review, interviews of Facility Director, Investigator, and PREA Coordinator, MOU with Alamosa PD, interview with random staff, review of PREA incident tracking log and review of agency website.

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The training program in use prior to the on-site audit did not meet all requirements, specifically mandatory reporting and treatment of transgender clients. The training program was revised to fully comply with this standard. Training records were not complete or not accessible during the on-site audit; however, given the additions to training, the training will need to be represented to all staff.

The training roster did not have a section for staff to sign indicating that they understand the materials presented in training, but this has been corrected.

The agency uses a PREA acknowledgement form as a synopsis of the individuals PREA responsibility, but these forms were not available for all staff. Policy states that training will be completed every year for all staff, so no refresher training will be given.

During the corrective action period, all components of this standard were adequately added into the training curriculum. Training records for all staff were reviewed and the Auditor conducted phone interviews during the month of July 2020, with staff to ensure understanding of the material.

Data Relied upon: Policy review, interviews of staff and clients, review of training curriculum, review of training rosters, review of individual staff member's personnel file and phone interviews with randomly selected staff in July 2020.

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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During the on-site audit, the agency enlisted the services of 2 volunteers (religious programming) and 4 contract staff who assist with the delivery of the IRT (Intensive Residential Treatment) program. The Auditor interviewed all 6 of these people (contract staff were contacted via phone). None of these individuals recalled being trained on PREA, but a few of them think they may have signed something about it at some point. The Auditor asked each person what they should do if approached by a client making a complaint about a PREA incident and all but one was able to communicate the correct procedure. (The volunteers stated that they also provided services to a jail and so they remembered from their training at the jail what to do.)

No evidence was provided to the Auditor to indicate that any of these six individuals had been trained on their PREA responsibilities. The policy indicates that volunteers will be trained annually but contract workers were not clearly addressed. In the absence of specific verbiage to address contract employees,

the Auditor placed them in the same category as staff – indicating that they also should be trained annually.

During the corrective action period, contract staff were trained regarding PREA and evidence of this training was provided to the Auditor. The Auditor conducted phone interviews with two contractors to confirm this training. (Since the on-site audit, only two contractors remain on the approved list for employment within the facility)

No volunteers have been trained because at this time no volunteers are approved for entry into the facility (due, in part, to the COVID-19 restrictions). If any volunteers return to provide services in the facility, including the two volunteers who were previously interviewed, they will be trained prior to being approved for re-entry.

Data Relied upon: Policy review, interviews of contractors and volunteers, observations during tours to ensure compliance with the standard, review of training rosters from July 2020, and phone interviews conducted in July 2020.

Standard 115.233: Resident education

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

115.233 (a)

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

115.233 (b)

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

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

During the on-site audit, the client education process was not found to be effective. Most of the clients interviewed did not know how to access help if a PREA incident were to happen. Some of them (mostly the clients who had been in prison) were able to surmise how to report an issue and most of these individuals were correct. The posters in place in the facility at the time of the on-site audit, showed a DOCTIPS line. While this phone number would probably work, it was not the correct phone number for reporting a PREA incident within the Colorado Department of Corrections. Additionally, many clients who were not sent to Alamosa from prison thought that this phone number was not one that they could use.

The client education program is completed by the client first reading and signing the paperwork, then they watch a PREA video, then a staff member reviews the information briefly, and finally, a formal "classroom" type of setting is used to reaffirm the information in the handbook and intake packet. The PREA information was not included in the formal classroom presentation, so the only PREA information received was from the intake packet and video (the PREA information is now included in the classroom presentation). If a client needs help to understand the information, staff take the time to read the information, or translate it into Spanish, if needed.

Advantage Treatment Center, Inc. has four locations in Colorado and occasionally, they do transfer clients between the centers. When this occurs, the client is treated as if they are new to the center and receive the same education as any other new individual client.

Each client signs the PREA Orientation form in the intake packet and this document is maintained by the center. At the time of the on-site audit the form they signed was not included in the handbook so they cannot refer back to the list of reporting contacts.

Prior to the issuance of the interim report the client handbook and intake process were expanded to incorporate all of the elements of this standard as well as standard 252 and 253. This information was added to the handbook so the client has a way to access the information after the intake process.

During the corrective action period, the posters that notify clients of PREA information were modified to include the correct phone numbers and contact

information for all types of clients (DOC and others). The facility re-educated clients regarding this information by correcting the posted notifications and by having each client sign a new PREA orientation information form that contained the added PREA information.

As a result of COVID-19 restrictions, the Auditor conducted random interviews with clients through a “zoom” meeting. The Facility Director facilitated this session by providing a lap top in each of the four dayrooms and then allowing clients to talk to the Auditor in each area. The Auditor interviewed 9 clients (four females and five males). These individuals were able to correctly respond to questions and several of them referred to the posters in the day rooms in which they were sitting.

Data Relied upon: Policy review, interviews of staff and clients, observations during tours, review of intake and client handbook, and the July 2020 zoom meeting that included interview with clients and views of the new information posted in each day room.

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

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

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This agency does not complete any investigation, criminal or administrative, for sexual abuse allegations. Therefore, this standard is compliant.

Data Relied upon: Policy review, interviews of staff, MOU with Alamosa PD, and review of PREA tracking log.

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

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

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

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

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

115.235 (b)

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

115.235 (c)

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

115.235 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This agency does not employ full or part time medical staff or mental health staff. However, the agency does employ Certified Addiction Counselors (CAC) who hold state certifications. These certifications range from a CAC1 to a CAC3. All CAC 1 and 2 must be supervised at a minimum of 3 hours per month by a CAC 3 or licensed Addiction Counselor (LAC). Advantage Treatment Centers is a licensed provider through the Office of Behavioral Health (OBH) to provide substance use disorder treatment. As such, they are not licensed to provide mental health specific care under this license. Much of the population presents with co-occurring disorders and OBH licensed the Alamosa facility at ASAM level 3.5 covering co-occurring enhanced programs. These staff do maintain Mental Health credentials (ex: LCSW, LPC, etc.) however, they solely focus on substance use and recovery related issued.

The Auditor reached out to the PREA Resource Center for interpretation as to whether these staff were considered mental health staff as defined by the PREA standards. The answer to this query was that these staff did in fact fall under the definition of mental health practitioner. As a result, the training required for this standard was developed after the on-site audit, with guidance from the resources on the PREA resource center website.

During the corrective action period, all certified addiction counselors attended a specialized training program that was designed to meet this standard as well as standard 261. This program was conducted through a zoom meeting, in part due to the COVID-19 restrictions. This training also included the updated training mandated for all employees.

As a result of COVID-19 restrictions, the Auditor conducted phone interviews with treatment staff to ascertain their understanding of the components of this standard.

Data Relied upon: Policy review, interviews of staff, observations during on-site audit, standard definition interpretation from the PREA Resource Center and the phone interviews of selected treatment providers conducted in July 2020.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

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

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

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

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

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

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

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

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

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

115.241 (e)

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

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

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

115.241 (f)

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

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency uses an objective screening instrument that includes all the elements required by this standard. Advantage Treatment Center, Inc. has four locations in Colorado and occasionally, they do transfer clients between the centers.

When this occurs, the client is treated as if they are new to the agency and receive the same education as any other new individual client.

The during the on-site audit, the Auditor reviewed 18 client files to ensure compliance with the timeframes in this standard. Ten of these files were from community corrections clients and 8 were from clients who were assigned to the IRT program. In this agency, when a client is moved from community corrections to IRT a new screening process is put in place with another 72 hour and then 30-day requirement for screening. The majority of these files indicated that the screenings were not being completed within the appropriate time frame. Upon further investigation, the Auditor was informed that case managers were instructed to complete the first screening within 72 business hours of the client's arrival and then the 30-day screening was to be completed within 30 days from the first screening. As a result, the files audited did not show compliance with this standard.

When the Auditor reviewed screenings for clients in the IRT program, the same type of non-compliance was found, with the additional concern that many of the 30-day reviews were not conducted at all.

During the corrective Action period, the agency clarified the requirements of this standard in order to show full compliance. As a result of COVID-19 restrictions, the Auditor reviewed compliance with electronic documents. The Auditor was provided a list of clients and randomly selected individuals. The facility then provided documents (electronically), to indicate compliance with the time frames required in this standard. Initially, compliance was not found with the clients in the IRT program and the Facility Director investigated the operational issues involved. It was found that the electronic documents did not accurately reflect the time frames due to a delayed data entry process that populated the current date. The facility was able to provide scans of paper documents that were used and that showed compliance with the time frames of this standard. The director will ensure that this process is modified to accurately reflect the screening dates.

Data Relied upon: Policy review, interviews of staff, review of client files, review of screening tool and review of screening forms of randomly selected clients in July 2020.

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The use of screening information is used consistently to inform bed decisions, however, because of the non-compliance with the timeframes in standard 241, the receipt of this information was delayed. The information is forwarded from the case managers to the Facility Director who then enters information into a spreadsheet and forwards it to the person in charge of reviewing bed assignments. This information is tightly controlled.

At the time of the on-site audit, the screening information was not being used to inform work or program assignments. The facility has only one volunteer work assignment, the kitchen. The individuals who are sent to work in the kitchen are normally the new arriving clients and this was often done prior to the first PREA risk screening. This practice needed to be modified to ensure that clients are not sent to work in the kitchen area without first being screened for risk with the goal of keeping separate those at high risk of being sexually abusive from those at high risk for being sexually abused. The screening information was not provided to the IRT program staff so that they could use the information to ensure they keep separate those at high risk of being sexually abusive from those at high risk for being sexually abused.

The agency does not provide educational programming.

The agency did not have a policy in place, prior to the on-site audit, that addressed the needs of transgender clients. This facility has not had a transgender client in the past so many of the components of this standard were not addressed in policy, practice, or training.

The physical plant of this facility has several different types of shower/bathroom arrangements, including more than one area where a client may shower in private. The facility can easily comply with the standard provision for all transgender clients to shower separately from other clients.

Prior to completion of the interim report, the agency added information to the policy to comply with the components of this standard relative to the placement and safety of transgender clients.

During the corrective action period, the facility modified operations to ensure that the screening information is available to make appropriate work and program assignments. The individual handling the work assignment process ensures that

no individuals who have been identified as a potential or past abuser will be assigned to the kitchen.

Additionally, the IRT coordinator, IRT case managers and treatment staff are now provided with information that indicates which individuals are at risk for victimization and which individuals are a risk for abusive behaviors.

As a result of COVID-19 restrictions, the Auditor conducted phone interviews with IRT staff and kitchen employees. The goal of these interviews was to ascertain that the staff were aware of this information and they were using the information to increase sexual safety within their areas.

Data Relied upon: Policy review, interviews of staff and clients, observations during tours, review of risk spread sheet and phone interviews conducted with staff during July 2020.

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

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

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

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

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The facility has multiple ways for staff and clients to report sexual abuse, sexual harassment, and retaliation. These reporting options are both internal and external to the agency and the client can remain anonymous. There is also a mechanism for staff to privately report sexual abuse or harassment. However, these multiple methods were not effectively communicated to clients or staff at the end of the on-site audit. The revisions necessary for compliance with standards employee training, 231 and resident education, 233, indicated the need to re-train staff and re-educate the clients.

Staff training has been modified to ensure that staff are aware of the need to accept and document reports of sexual abuse and harassment made verbally, in writing, anonymously and from third parties. Staff interviews that were conducted on-site indicated that staff were aware of this responsibility, but there was no formal training or policy document that supported their stance.

External avenues for reporting include contacting the community parole officer, Colorado Department of Corrections PREA reporting line, Colorado Department of Corrections PREA office, Probation Liaison, District Attorney's victim advocate or contacting the Alamosa Police Department. This list of outside contacts was verified by the Auditor during the on-site portion of the audit. Each person/phone number listed was called and the Auditor questioned the appropriate individuals about their ability to take a complaint and the process to report the information to the agency officials.

A completed Memorandum of Understanding has been finalized between the facility and the District Attorney's Victim Advocate.

During the corrective action period the facility was able to complete a written agreement is for Tu Casa Services for emotional support and assistance from a victim advocate from a rape crisis center.

Client re-education and staff re-training has been completed to ensure that clients and staff are aware of the avenues available for reporting. This information is available to both staff and clients in a manner that will continuously provide them access to these resources.

As a result of the COVID-19 restrictions, the Auditor confirmed compliance with this standard by interviewing clients through a "zoom" conference and by contacting staff through a phone interview.

Data Relied upon: Policy review, interviews of staff and clients, observations during on-site audit, information gained by calling each external contact individual/office, review of pending and signed MOU's, zoom interviews with clients and phone interviews with staff, July 2020.

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency is exempt from this standard, therefore, meets the standard. The agency PREA policy specifically states: "the formal grievance process is not to be used for such issues." The inmate handbook also includes a statement that indicates that the grievance system is not to be used for PREA issues:" The Grievance Process should not be used to report any PREA incidents. Please see PREA section of handbook for reporting process", page 38.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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At the time of the on-site audit, the components of this standard were not in place, however, the facility was in the process of establishing a relationship with the local rape crisis center, Tu Casa, to provide emotional support services to clients. A signed MOU has been finalized between the facility and Tu Casa.

Information has been included in the client handbook that provides contact information and to communicate that no phone calls are monitored and no mail is censored or read.

Data Relied upon: Policy review, interviews of staff and clients, observations during on-site audit, interview with Tu Casa representatives, and review of education provided to clients.

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The agency website includes the following statement:

Fellow residents, family members, attorneys, medical personal, or outside advocates will be encouraged to report any suspicions or allegations as well through any of the following avenues.

- Direct verbal or written report to any ATC staff member, contractor/vendor, or ATC volunteer
- Contacting local law enforcement

- U.S. Mail, kite, note, or any other written method
- Calling the ATC PREA Coordinator, Kristie Garcia, at 970-571-3983
- Emailing the ATC PREA Coordinator, Kristie Garcia, at kristie.garcia@advantage-tx.com
- Emailing the VP of Operations, Josh Mayhugh, at josh.mayhugh@advantage-tx.com

For confidential reporting:

- For DOC clients: call PREA reporting @ 1-855-855-0611
- For all clients: Send a letter to the DOC PREA Manager, DCJ Director, or Contact the local Community Corrections Board.

Data Relied upon: Policy review, review of agency web-site and the interview with the PREA coordinator.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

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

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

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary,

as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.261 (c)

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

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

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The policy did not adequately cover all components of this standard prior to the on-site audit but changes were made to comply with all aspects of this standard.

As reported earlier (in standard 235) the certified addiction counselors are considered mental health practitioners, therefore, the requirements in section C of this standard needed to be addressed.

During the corrective action period, the mental health practitioners were trained to comply with section C of this standard: Unless otherwise precluded by Federal, State, or local law, mental health practitioners are required to report sexual abuse pursuant to paragraph (a) and mental health practitioners are required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.

As a result of COVID-19 restrictions, the Auditor conducted follow up phone interviews with treatment staff to ascertain their understanding of the requirements of this standard.

Data Relied upon: Policy review, interviews of staff and clients, standard definition interpretation from the PREA Resource Center, staff training curriculum, new training curriculum developed for treatment staff and phone interviews with treatment staff during July 2020.

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency policy clearly states: Agency Protection Duties: When staff learns that a client is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the client.

Staff interviews revealed that staff were aware of this responsibility.

Data Relied upon: Policy review and interviews of staff.

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The facility complies with all components of this standard. There was one incident within the last year that demonstrates their compliance and documentation was reviewed that confirmed the process and timeframes were met. Policy is in compliance with this standard also.

Data Relied upon: Policy review, interviews of Facility Director and PREA coordinator and review of PREA tracking information.

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

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

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

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The facility complies with all components of this standard. Interviews with staff confirm that they are aware of their first responder responsibilities. The facility has issued all staff cards that detail the PREA first responder actions. These cards are designed to attach to the back of their IDs. Action steps listed are in line with the standard requirements and are in line with the training curriculum.

This facility has designated all staff, including treatment staff and kitchen workers as first responders, so there is no difference in duties between security staff and others

Data Relied upon: Policy review, interviews of staff, examination of cards that list the PREA first responder actions, and review of training curriculum.

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

A written institutional plan that coordinates actions between facility staff, medical and mental health practitioners, investigators, and facility leadership was not in existence in a concise manner at the time of the on-site audit.

Corrective Action completed: All components of this standard were added to policy.

The facility initiated a Memorandum of Understanding to ensure that all agencies/individuals involved were aware of the PREA requirements. At the time of this report, this MOU has not been fully executed. While this MOU will be an effective mechanism to document the coordinated response, the current policy is effective and clear.

Data Relied upon: Policy review, interviews of staff and clients, observations during tours to ensure compliance with the standard.

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This agency does not have a collective bargaining agreement with employees. Therefore, they are not responsible for collective bargaining or entering into or renewing any collective bargaining.

The standard requirements are compliant.

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The facility has implemented policy and practice to ensure that monitoring for retaliation is consistently completed. The Facility Director is assigned the responsibility of this monitoring duty. The PREA tracking form includes monitoring duties and any actions taken.

Multiple methods of protection are available for clients as the facility has many options to use for a variety of different types of housing. There is also Employee Assistance Program in place to provide emotional support for staff.

Data Relied upon: Policy review, interviews with Facility Director, and review of PREA tracking form to check for monitoring.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

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

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

115.271 (b)

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

115.271 (c)

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

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

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

115.271 (e)

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

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

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The facility does not conduct investigations, either criminal or administrative, for sexual abuse allegations.

Administrative investigations are conducted by the facility for allegations of sexual harassment or other non-criminal sexual behaviors. These investigations include a determination of whether staff actions or failures to act contributed to the issue and contain a thorough description of evidence relied upon.

Criminal investigations are referred to the Alamosa Police Department. The facility has completed a MOU with the Alamosa Police Department. However, sections D and E are not covered in this MOU:

D.When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?

E. Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?

Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?

During the corrective action period the agency was not able to get a new MOU completed to include these sections of the standard, however, they were able to provide written documentation from the Alamosa Police Department that indicates compliance with these two sections. The MOU should be pursued to allow for all of this information to be easily accessible in one place.

Data Relied upon: Policy review, review of draft MOU -coordinated response and the documentation provided from the Alamosa Police Department, Chief Ken Anderson dated July 21, 2020.

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy clearly states:

a. Evidentiary Standard for Administrative Investigations

   i. The facility shall impose no standard higher than a preponderance of the evidence in determining whether

allegations of sexual abuse or sexual harassment are substantiated.

Interview with assigned investigator and Facility Director confirm this level of evidence.

Data Relied upon: Policy review and interviews of Facility Director and assigned investigator.

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

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

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

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the

resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

All components of this standard are specifically addressed in policy. The Auditor reviewed on-site documentation on the PREA tracking form to confirm follow up and documentation. The documentation is complete and clearly demonstrates compliance. The facility tracks the follow up action for all PREA incidents, not just those alleging sexual abuse.

Data Relied upon: Policy review, interviews of Facility Director and PREA coordinator and review of PREA tracking form.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Prior to the PREA audit, all components of this standard were not covered in policy.

Corrective Action completed. Policy has been modified to address all components of this standard. Additionally, a memo from the clinical director has been provided that indicates that all actions found to be in violation of the Mental Health Practice Act or code of ethics will be submitted to DORA (Department of Regulatory Agencies).

Data Relied upon: Policy review, interview of the Facility Director and PREA coordinator, PREA tracking form, and Licensure compliance with PREA standards memo from clinical director.

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Prior to the audit, agency policy did not specifically cover the components of this standard.

Corrective Action completed: Agency policy has been modified to cover all aspects of this standard as it applies to volunteers or contract employees. As noted in the previous standard, the same memo from the clinical director would apply, if applicable, and all actions found to be in violation of the Mental Health Practice Act or code of ethics will be submitted to DORA (Department of Regulatory Agencies).

Data Relied upon: Policy review, interview of the Facility Director and PREA coordinator, PREA tracking form, and Licensure compliance with PREA standards memo from clinical director.

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.278 (e)

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

115.278 (f)

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

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the Auditor's analysis and reasoning, and the Auditor's

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

All sexual activity between clients is prohibited. As such, engaging in sexual activity is normally dealt with by regressing the individual from the program. However, this decision is not automatic and a full review is completed, including consideration of whether the clients has a mental illness or disability that may have impacted their behavior.

The Auditor reviewed data from the disciplinary process at this facility. During the past 12 months, there have been 2 disciplinary hearings for clients who have engaged in sexual acts/harassment.

Data Relied upon: Policy review, interviews of PREA coordinator, Hearing Process Training curriculum, and review of disciplinary action records.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This facility does not employ medical staff or qualified mental health staff, therefore all access to emergency medical and mental health services is accessed from the community. A "qualified medical practitioner" refers to such a professional who has also successfully completed specialized training for treating sexual abuse victims.

The facility relies upon the emergency response capabilities of the community to ensure adequate and timely care. The policy clearly delineates the components of this standard. The facility policy covers all aspects of this standard, including timely access to emergency contraception and sexually transmitted infections prophylaxis.

Memo from VP of operations, dated Feb 11, 2020, indicates that the cost will not be the responsibility of the client. The memo includes information that indicates the agency will attempt to get these costs covered by grants or other options and

provides direction for Facility Directors regarding where to send any type of bill for services.

An MOU with medical care providers has been completed.

Data Relied upon: Policy review, memo from VP of Operations regarding costs, and review of MOU for medical response.

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

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

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be*

residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.) ☒ Yes ☐ No ☐ NA

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy includes all components of this standard. Ongoing medical and mental health care for sexual abuse victims and abusers is available through community agencies. This facility relies upon the community medical and mental health resources to comply with these provisions. The cost for any such care will not be the responsibility of the victim, regardless of whether the abuse occurred at this facility or at another correctional entity. The agency will ensure coverage of the cost.

The local community corrections board may approve for placement in the Alamosa facility individuals who are in need of sex offender treatment. In such cases, the client will be referred to Behavioral Health Group sex offender treatment provider. If the client is accepted into this treatment, the treatment will be covered for eight sessions. After these eight sessions are completed, the client is responsible for all other costs. The determination of treatment need is made by the treatment provider, but the process is usually started by the parole officer of probation officer.

In the event that an act of sexual abuse is perpetrated against a client by another client, the abuser will not be offered treatment, but will be removed from the facility and regressed back to the appropriate agency.

Data Relied upon: Policy review, draft MOU for coordinated response, and interview with Facility Director and the representative from the Community Corrections Board.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No

- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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All components of this standard are included in policy, however, there have not been any incidents of sexual abuse in the past year. This agency has

implemented a two-tier approach to incident review. All incidents of sexual abuse will be reviewed at the facility level. Additionally, the results of the sexual abuse incident reviews will be shared with the Facility Directors from all facilities to ensure a complete understanding of issues that were identified for resolution in an attempt to prevent them from re-occurring.

A review has not been conducted at this facility as there have not been any incidents that involved sexual abuse.

Data Relied upon: Policy review, interviews of staff and clients, interview with the PREA coordinator, and observations during tours to ensure compliance with the standard.

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

All components of this standard are addressed in policy and are in evidence in practice. The Survey of Sexual Victimization, 2018 was compared to the data collected by this agency and no omissions were found.

Data Relied upon: Policy review, interviews of PREA coordinator, Survey of Sexual Victimization, 2018, and review of PREA tracking form.

Standard 115.288: Data review for corrective action

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

115.288 (a)

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

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

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

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The policy covers all components of this standard. The facility's annual report is approved by the Agency Head and is available on their agency website. This current annual report did not include a comparison of prior year's data as the data collection and annual reporting has not be completed prior to this year. The data and processes are in place to ensure that data can be analyzed against future incident data.

Data Relied upon: Policy review, interviews with the PREA coordinator, and review of annual report.

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

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

115.289 (b)

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

115.289 (c)

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

115.289 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy covers all components of this standard. The data that is made available to the public, through the agency website, is aggregated and does not have any personal identifying information included. All data will be retained for at least 10 years.

Data Relied upon: Policy review, interviews with the PREA coordinator, PREA tracking form and Annual report.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

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

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

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Audit notices included information regarding ways to send confidential correspondence to the Auditor. No such correspondence was received.

During the on-site portion of the audit, the Auditor was given access to all requested records and all areas of the facility.

The Auditor was present during all three staff shifts and in each of the living units and treatment areas.

The Auditor was provided a location to conduct private interviews with both staff and residents.

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

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This facility has not been audited in the past three years. This facility was moved under the management of ATC in May 2017.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Susan Jones **Click here to enter text.**

Auditor Signature **Date**

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

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.