PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: October 13, 2017

Auditor Information			
Auditor name: Kayleen Murray			
Address: P.O. Box 2400 Wintersville, Ohio 43953			
Email: kmurray.prea@yahoo.com			
Telephone number: 740-317-6630			
Date of facility visit: August 29-30, 2017			
Facility Information			
Facility name: Cornerstone			
Facility physical address: 2216 Vine Street, Cincinnati, Ohio 45219			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 513-684-7965			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Thomas Bach			
Number of staff assigned to the facility in the last 12 months: 28			
Designed facility capacity: 60			
Current population of facility: 65			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 18 & up			
Name of PREA Compliance Manager: Erica Bailey		**Title:** Associate Director	
Email address: Erica.Bailey@talberhouse.org		**Telephone number:** 513-684-7965	
Agency Information			
Name of agency: Talbert House, Inc.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 2600 Victory Parkway, Cincinnati, Ohio 45206			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 513-861-1718			
Agency Chief Executive Officer			
Name: Neil Tilow		**Title:** President/CEO	
Email address: Neil.Tilow@talberthouse.org		**Telephone number:** 513-751-7747x1051	
Agency-Wide PREA Coordinator			
Name: Karla Wilson/Cathy Jo Vanderpool		**Title:** Compliance Manager/Director of Regional Corrections	
Email address: Karla.Wilson@talberthouse.org/cathy.vanderpool@talberhouse.org		**Telephone number:** 513-751-7747	

AUDIT FINDINGS

NARRATIVE

The PREA audit for Cornerstone Halfway House was conducted on August 29-30, 2017 in Cincinnati, Ohio. As part of the Talbert House residential corrections program, the facility focuses on successful transition from correctional supervision to community. The facility supplied the auditor documentation relevant to showing compliance with each of the standards. This documentation included the pre-audit questionnaire, policy and procedure, facility floor plan with camera coverage marked, MOU's, staffing plan, and other PREA forms. The auditor received this information and additional documentation while conducting the onsite visit.

During the audit, the auditor toured the facility and conducted informal and formal staff and client interviews. It was noted during the tour that multiple PREA audit notices were posted in conspicuous places throughout the facility. The notices included the name and address of the PREA auditor and the date posted was six weeks prior to audit. All client areas including the bathroom has posters which informs clients on the ways in which they can report an allegation; the phone numbers and addresses of agencies they can report including anonymously; and that they can report to any staff member at any time in writing or verbally. Staff post areas have a PREA posters which includes first responder duties and the facility's coordinated response plan.

Six random clients were interviewed, based on the facility's current population level. There were no residents who identified as LGBTI, so a random sample of clients was chosen from the various dorm rooms. Residents were asked about their experience with PREA education, allegation reporting, communication with staff, safety, restrooms, knock and announcements, grievance procedures, pat downs, PREA brochures and postings, and the zero tolerance policy.

Also interviewed were specialized staff. This staff includes the PREA Coordinators (also Investigator), PREA Manager (facility Associate Director), Resident Advisor (RA) Practitioner, Director, Human Resource Generalist, and Case Manager. The local hospitals SANE Coordinator, and Women Helping Women Director were not able to be interviewed. The auditor reviewed both agencies' websites and MOU agreement. The facility does not provide on-site medical or mental health services related to forensic examinations. Random staff were questioned about PREA training, how to report, to whom to report, filing reports, investigations, conducting interviews, follow-up and monitoring retaliation, first responder duties, and the facility's coordinated response plan.

After a brief opening with agency staff, the auditor toured the facility. The tour consisted of examining all dorm areas, group rooms, day rooms, bathrooms, operations post, utility areas, and maintenance areas. A review of employee files, training records, PREA acknowledgments, PREA forms, and data logs were also completed. The auditor gave a closeout and shared some of the immediate findings.

DESCRIPTION OF FACILITY CHARACTERISTICS

Cornerstone is a halfway house located in Cincinnati, Ohio that serves adult male felony offenders. The facility is three separate renovated houses that are connected by a courtyard in the rear of the buildings. The buildings are multilevel and house both state and federal commitments. All clients have access to all three buildings and must use the center building to enter and exit the facility. The facility can house up to 60 offenders; however, it is currently housing 65. To access the facility, one must be buzzed into a lobby area in the center building where they will be sign-in by staff. Clients would access the same entrance and be subject to a pat-down in the duty office which is visible by video surveillance.

The facility is equipped with 24 surveillance cameras which can record and play back up to seven days. The cameras are placed strategically throughout the interior and exterior of the building. There are also multiple security mirrors to enhance security in vulnerable areas. The facility has identified areas that can be considered vulnerabilities and have developed a plan for monitoring these areas until electronic monitoring can be added. The center building contains the administration area and the main security post. From this post, the security staff can view all cameras. The basement of this building houses the laundry area and an exercise room. Both of these rooms are covered by electronic surveillance. There are housing units on the upper floors. There are two dorms across the hall from each other that share a bathroom. The dorms have areas inside that a separated by walls. This makes it difficult for clear line of site views into the room. Resident Advisor (RA) staff are required to enter the room and check all areas during circulations and head counts. The facility has drafted a plan to purchase cameras for the dorm rooms. Clients are informed that they must dress in the bathroom. The top floor of the building has the lounge area and staff offices. The staff offices have outer door that is solid and within the room are three offices. All office doors are solid. The staff have their doors open when clients are inside. State Building A has the kitchen and dining hall for all offenders. The clients are not allowed to enter into the back kitchen area. They line up to receive meal trays and take them into the dining hall. The dining hall is open to clients until lights out. The upper floors of this building have staff offices, offender lounges, and dorm areas. The dorms are open rooms with no wall dividers. The bathroom on the floor is shared by both dorms. The bathroom contains two toilet stalls with doors and two individual shower stalls with curtains. State building B is the smallest of the three. The building only houses nine offenders. The first floor occupies the day room, group room, and a urinalysis office. The top floor has a single dorm room and multiuse bathroom. The bathroom is equipped with two toilets with doors and two individual shower stalls with curtains. The facility requires Resident Advisors to conduct head counts during the day and circulation rounds every 30 minutes, as well as security and perimeter checks throughout the facility. Resident Advisors (RA) are required to conduct more frequent checks in areas that are considered blind spot areas. Clients who need to see staff such as a case manager, will need to go to the main control post and get permission before entering a staff office hallway.

The facility has several housing units. Some of these dorms in these units are divided by wall barriers and limit the number of beds in each contained area. Clients that have been given a classification of vulnerable would be housed in one of the dorm rooms that offers the most visibility and security. All rooms are designed to minimize blind spot areas. The bathroom is designed to offer privacy for clients (see standard 115.215 to see full bathroom description). Clients are required to be out their rooms during program hours.

The facility offers several programs designed to successfully reintegrate offenders back into the community. Reentry Services include addiction treatment, medication-assisted treatment, trauma, life skills, vocational services, and criminal thinking. The organization has a culture of innovation that thrives on the creation of services that meet clients' needs. Treatment services are researched based, best practices. The staff provide a secure, supervised, and structured living environment that empower clients to change.

SUMMARY OF AUDIT FINDINGS

Cornerstone Halfway House has had three PREA allegations of staff sexual misconduct during this audit cycle. The allegations where administratively investigated and referred for criminal investigation if needed. Agency administrative staff conducted SART reviews on the allegations and developed necessary plans to correct deficiencies. Cornerstone staff interviewed indicated that they received formal PREA training during orientation as well at facility meetings as part of their annual training. Staff on all three shifts including security and program staff were able to discuss their responsibility as a first responder, how to report or respond to an allegation of sexual abuse, sexual harassment, or retaliation.

Staff were sure of their education and training and would be capable to responding to any allegation appropriately. Clients interviews from the facility seemed well versed on their rights under the PREA standards and knew who and how they could report including anonymously. All clients receive information at intake with the phone number and address of inside and outside agencies that could help and knew the location of posters. Services with the Women Helping Women for victim advocacy services and with the University of Cincinnati Hospital for SANE practitioners are in place.

Overall, the auditor was left with the impression that the leadership and staff of Cornerstone have made implementing the PREA standards a priority and that they have received the necessary training and authority to detect, protect, and respond to any incident of sexual abuse/sexual harassment. Talbert House as an agency has reviewed the corrective action plans from other facility's and have implemented positive changes at all facilities. Opportunities to increase the ability to protect and detect sexual abuse and sexual harassment are proactive in nature. Agency leadership has developed policies and practices that shows a commitment to the safety of residents, and provides the necessary support to implement all aspects of the PREA standards.

This is the facility's second PREA audit and it confirms the agency's progression toward providing maximum safety and an environment where staff can enable positive change

Number of standards exceeded: 0

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 2

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Cornerstone adheres to the Talbert House agency zero tolerance policy. The policy outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

The agency's Director of Regional Corrections and Compliance Manager serve as the agency wide co-PREA Coordinators and reports to the agency's Vice President of Court and Corrections. The auditor spoke with both PREA Coordinators concerning their authority to develop, implement, and oversee the agency's efforts to comply with PREA standards. During the interview, it was clear that both PREA Coordinator has sufficient time and authority to implement the agency's policies and practices in an effort to obtain and maintain compliance.

At the Cornerstone facility, the Associate Director serves as the facility PREA manager. The Associate Director would report any PREA related issues to the Coordinators. During the interview, the Associate Director noted that she has sufficient time and authority to implement all policies and practices related to obtain and maintaining compliance with PREA standards.

Review:
Policy and procedure
Interview with PREA Coordinators
Interview with PREA Manager/Associate Director
Interview with Director

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A: The PREA Coordinator reports that the facility is operated by a private agency and does not contract with other agencies for offender placement

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency has a policy requiring each facility complete a staffing plan that provides for adequate levels of staffing and where appropriate video monitoring equipment to protect clients against sexual misconduct. The staffing plan reviews the physical elements of the building including the placement of cameras and identified blind spot areas; plans for prevention and detection including coverage of blind spot areas, requiring staff to have blinds or doors open when clients are in the office, and proper training to ensure staff are conducting proper and timely tours throughout the facility; and ensuring proper staff to clients ratios and that staff have been properly trained on the PREA standards. The plan also reviews the number and types of allegations during that year and ensures all recommendations have been implemented.

The facility has a total of 24 cameras (internally and externally) that aid in the supervision of clients. The cameras record to a digital server and are capable of a seven-day play back. The facility is located in a group of three buildings with each having multiple floors. Staff, clients, and visitors must be "buzzed in" to the lobby area of the main entrance that is staffed with a Resident Advisor (RA) 24 hours a day. This staff member will monitor cameras, complete pat downs on clients entering the building, and sign clients in and out of the building. There is no access to the group of buildings without entering through the main entrance first. Once inside the complex, clients can move between buildings through the courtyard. Clients have free access to a recreation and smoke break area that is surrounded by a fence/wall. RA staff complete three head counts and constant circulation throughout the complex. Third shift complete a count every hour.

The plan is required to be reviewed annually.

There have been no reports of deviations to the staffing plan.

Review:
Policy and procedure
Facility tour
Staffing plan
Floor plan
Interview with PREA Coordinators
Interview with Associate Director

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Per agency policy, the facility does not conduct cross gender or body cavity searches. The facility houses only male clients and all RA staff completing pat downs are male with female staff being used as witnesses. All pat downs are completed in camera view. The facility does not conduct strip searches. All employees are trained on the proper techniques to a pat down search during orientation and again annually.

The facility allows for clients to shower, perform bodily functions, and dress in areas not viewable to staff. The clients within each dorm

area on the same floor share a bathroom. The bathroom is equipped with three toilet stalls with doors, three individual shower stalls with curtains that open up to a changing area that is covered by a shower curtain. There are two urinals across from the shower area. The bathroom on the third floor of this building has the same set up. In State Building A, The two dorm areas share a bathroom that is located just outside the smaller dorm. The bathroom is equipped with two toilet stalls with doors and two individual showers with curtains. State Building B has one dorm that is across from the only bathroom. The bathroom is equipped with two toilet stalls with doors and two individual shower stalls with curtains. All bathrooms have a solid door entrance. Females are announced when coming into dorm areas and again when entering the bathroom. The facility has not had an incident of incidental viewing. The facility has a plan to install cameras in the dorms and has put in place a dress policy that requires clients to dress in the bathroom.

The facility has not housed a transgender or intersex client. The agency has developed a transgender housing policy that has identified ways to manage, house, and secure a transgender or intersex client safely. The Cornerstone facility is capable of housing a transgender or intersex client safely. Once identified, the client will be place in State Building B. This building housing a maximum of nine clients. The client will be consulted as to their needs for privacy concerning personal hygiene and preferences on who would conduct pat downs. The agency has a policy for professional, respectful transgender/intersex client pat downs. No transgender/intersex client would be searched for the sole purpose of determining genital status.

During interviews with staff, all indicate that they have been trained properly on how to conduct a variety of pat downs. The staff members felt comfortable with their training and no issues have been reported concerning the pat down process.

During interviews with clients, the auditor noted that all clients reported that the pat downs were conducted professionally and respectfully. At no time did a resident complain that they were uncomfortable in a sexualized way during a pat down.

Review:
Policy and procedure
Facility tour
Interview with Associate Director
Interview with Director
Interview with random staff
Interview with random clients
Interview with PREA Coordinator

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy that calls for the reasonable accommodations for clients that allow for them to be able to benefit from program services. These services are for clients who may have a physical, mental, or cognitive disability or for clients who may be limited English proficient. The facility works with community partners to address specific individual needs so that clients can benefit from all aspects of the facility's efforts to prevent, detect, and respond to incidents of sexual abuse and sexual harassment.

The facility staff are instructed to ensure that all aspects of PREA are communicated to all clients regardless of mental, physical, or cognitive disability or language barrier. If there is not a qualified staff member to assist the client, a community partner will be contracted to aid the client in understanding agency rules, PREA, and other regulations. The agency currently has partnerships with Affordable Language Services, VocaLink, and Hearing, Speech, and Deaf Center of Greater Cincinnati.

At no time will another client be used for interpretive services unless a delay in services would compromise the client's safety, the performance of first responder duties, or an investigation.

The facility does not currently house any client needing these services; however, has in the past partnered with Affordable Language Services.

Review:
Policy and procedure
Interview with random staff
Interview with Associate Director
Invoice for Affordable Language Services

Standard 115.217 Hiring and promotion decisions

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

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

Talbert House has a policy that prohibits any of the facilities it operates to hire or promote staff (including contractors and volunteers) that have been convicted of sexual abuse in a prison, jail, lockup, or community confinement facility, nor will they hire or promote anyone who has been civilly or administratively adjudicated to have engaged in sexual abuse in the community. The facility conducts a NCIC/NLETS background check on all employees and volunteers. Staff members who work in a facility that houses federal Bureau of Prison offenders will automatically receive a background check every five years as part of the contract renewal. A random review of 12 employee files shows that all employee background checks are up to date. The agency documents all contact with previous employers.

The employee application requires all applicants to reveal if they have been convicted of sexual abuse in a prison, jail, lockup, or community confinement facility or convicted of engaging or attempting to engage in sexual activity in the community by force (over or implied) or coercion, or if the victim did not consent or was unable to consent; and if they have been civilly or administratively adjudicated to have engaged in the above activity.

The agency also has a PREA acknowledgement form that all staff sign. The form reviews the agency's zero tolerance policy and all expectations under the PREA guidelines including the continuing affirmative duty to report any allegation against the employee. New employees are also trained on ethical and professional conduct and scope of practice, prevention of personal or familial relationships with clients, and professional boundaries.

Employees who would like to move up within the agency will have to submit a letter of interest to the HR Department. The HR Department will assess the eligibility of the employee by reviewing performance appraisals, disciplinary records, and personnel action reports. Employees who have a disciplinary report that includes a substantiated allegation of sexual harassment will not be considered for the position.

The auditor reviewed 12 random employee files. The review included on boarding documentation, employment application, reference checks/verification, interview forms, disciplinary records, training records, background checks, employee handbook, code of conduct/ethics acknowledgement, and promotions.

The auditor interviewed the Human Resource Generalist concerning their method for ensuring all employees receive their initial and five-year background checks, the process for promotions, and the onboarding process.

Review:
Policy and procedure
Employee zero tolerance acknowledgement
Employee files
Onboarding documentation

Background checks
Interview with HR Generalist

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility has not acquired any new facility nor is it planning any substantial expansion or modification to the current facility. The facility constantly reviews the facility for needs to its video monitoring system. This includes taking into consideration how such technology may enhance its ability to protect residents from sexual abuse.

Facility management review the staffing plan annually in order to access the effectiveness of the facility's security program and if improvements in the electronic monitoring could help in the prevention, detection, and responding to sexual abuse and sexual harassment. The facility is planning to add additional cameras throughout the living areas. There is no other need for additional electronic monitoring or increased staffing levels. The PREA Coordinator will continue to monitor and request additional resources as needs arise.

Review:
Facility tour
Floor plans
Interview with PREA Coordinator
Interview with Associate Director
Interview with Director

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility conducts administrative investigations into allegations of sexual abuse and sexual harassment. If at any time during the investigation the incident appears to be criminal in nature, the PREA investigator will refer the case to the legal authority for a criminal investigation. The facility has an MOU with the City of Cincinnati Police Department as they have the legal authority to investigate criminal conduct at the facility. The department has agreed to use "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents" as the uniform evidence protocol in which to investigate any criminal allegations.

The facility will send clients to University of Cincinnati Hospital where they perform forensic exams as no cost to the victim. The auditor reviewed the hospital's website to confirm the services of a SANE practitioner and advocate services. Talbert House has a MOU with

Women Helping Women to provide advocate and emotional supportive services.

University Hospital has a SANE nurse on staff 24 hours a day 7 days a week. These nurses have been trained in forensic nursing and crisis intervention clinical competencies. Women Helping Women would provide an advocate to offer emotional support, crisis intervention, and follow up services.

Review:
Policy and procedure
MOU with Women Helping Women
MOU with City of Cincinnati Police Department
Emotional support person certificate
Review of University of Cincinnati Hospital's website
Review of Women Helping Women's website
Interview with Director
Interview with Associate Director

Standard 115.222 Policies to ensure referrals of allegations for investigations

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

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The agency has a policy that regulates an administrative investigation of all allegations of sexual abuse and sexual harassment. The policy ensures that any allegation that appears to be criminal in nature is referred to the legal authority in charge of conducting a criminal investigation. The facility has a MOU with the City of Cincinnati Policy Department, the agency who has the legal authority to conduct such investigation. The agency has posted its policy concerning conducting an administrative and criminal investigation on its website (http://www.talberthouse.org/resources/prea-5/). During this audit cycle, the facility has had three allegations.

Investigation #1: A client made a sexual abuse allegation against a staff member. The allegation was referred to the Cincinnati Police Department for criminal investigation and an internal administrative investigation also took place. The administrative investigation determined that the allegation was not founded. The police department determined there was no criminal activity. During the investigation, the clients was moved to another halfway house facility and a rescreen was conducted.

Investigation #2: A staff member made a suspicion report on an inappropriate relationship between a staff member and client. The facility conducted an administrative investigation and referred the allegation to the Cincinnati Police Department. Both investigation determined the allegation to be unfounded. During the investigation, the staff member was transferred to another facility and the client received a risk assessment rescreen. After the investigation was complete, staff was retrained on who to manage rumors and when it is appropriate to intervene in situations.

Investigation #3: A client made a retaliation report against a staff member claiming he was be retaliated against because he ended the relationship with staff. The client would not provide any evidence to his claim. The Bureau of Prisons also investigated allegation. The allegation was determined to be unsubstantiated. The client is no longer at the facility due to an escape charge.

Review:
Policy and procedure
Agency website
Interview with PREA Coordinator
Investigation reports
Administrative reviews

Retaliation reports

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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All employees receive orientation training during their onboarding at Talbert House. This training includes PREA related topics. During this training staff learn from experienced trainers on practical and facility specific ways to manage PREA related situations. At training, staff also learn how to detect blind spot areas; conduct pat downs, strip searches, and transgender/intersex pat downs; and complete searches. The classroom part of the training includes:

Gender specific training
Code of ethics
PREA assessment and the use of screening information
Resident reporting
Boundaries
Investigations
First responder duties/coordinated response plan
Client rights under the PREA guidelines
PREA policies
Rights and responsibilities for incidents of sexual abuse, assault, harassment, and retaliation
Symptoms of abuse
LGBTI populations
Victim medical/mental health care

In addition to orientation training on PREA topics, employees also receive, PREA related training annually. All training is tracked and a copy is kept in the employees file.

CORRECTIVE ACTION:
The facility offers the required specific training identified in 115.231; however, the training is only mandatory during orientation. Staff members may choose Relias online training to fulfill the training requirement for other years. A review of the Relias online training showed that it lacked training on how to communicate effectively and professionally with residents including, lesbian, gay, bisexual, transgender, intersex, or gender non-conforming. This training is allowable for the off year of the biannual training requirement, but not on an annual basis.

FACILITY RESPONSE:
The PREA Coordinators met with all facility Directors and Associate Directors and clarified the training requirement. Talbert House offers training classes throughout the year via the agency's Institute for Training and Development that any staff member can attend. The facility Directors and Associate Directors will ensure staff participate in the facilitated training that covers all required topics on a biannual basis.

Review:
Employee files
Training curriculum
Staff rosters
Interview with Training Coordinator
Interview with PREA Coordinator
Interview with random staff

Interview with Associate Director
Interview with Director
Court and Corrections Service Meeting Minutes

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency requires all contractors and volunteers to participate in training before having contact with clients. The training includes a review of the agency's zero tolerance policy, how to prevent, detect, and respond to allegations of sexual abuse and sexual harassment. All contractors and volunteers are required to sign verification of training. Visitors to the facility must read and acknowledge Talbert House's zero tolerance policy.

At the time of the audit, there were no contractors or volunteers in the facility.

Review:
Policy and procedure
Visitor zero tolerance acknowledgement form/sign-in sheet
Contractor/volunteer zero tolerance acknowledgement form
Interview with PREA Coordinator

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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All residents receive information at intake on the facility's zero tolerance policy. This information is reviewed with the client to ensure that each client knows how to report incidents or suspicions of sexual abuse or sexual harassment; their right to be free from sexual abuse, sexual harassment, and retaliation; and how to keep themselves safe while in the facility. If a resident is limited in English proficiency or another disability that prevents, normal communication, the facility will work with outside agencies to ensure each client can benefit from the agency's efforts to prevent, detect, report, and respond to allegations of sexual abuse and sexual harassment.

At intake clients will receive brochures and other documentation that provides phone numbers and addresses to reporting and supportive agencies. This information is also documented throughout the facilities on posters located in conspicuous places. A more formal client education concerning their rights and responsibilities under the PREA standards is given at a later time.

The facility provided the auditor with the documentation that is given to clients, and noted the posters located throughout the facility.

In total, six clients were interviewed by the auditor (10% of the current population). The clients acknowledged receiving PREA education training and informational brochures from the facility. All clients reported feeling safe in the facility and comfortable enough with staff to report an allegation if necessary Clients were aware of the PREA postings and the toll free phone numbers available if they needed to contact a hotline or other supportive services. Clients in this facility are also able to have a personal cell phone.

Review:
Policy and procedure
Client education curriculum
Client education roster
Client PREA brochure
PREA posters
Client support documentation
Facility tour
Interview with random clients
Interview with PREA Coordinator

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy concerning specialized training for PREA administrative investigators. All criminal investigations are referred to the local legal authority for investigation. Pathways has two staff members that have received appropriate training on how to conduct an administrative investigation. The training included techniques for interviewing sexual abuse victims, proper use of Miranda and Garity Warnings, evidence collection in a confinement setting, and required evidence to substantiate a case for administrative or criminal investigation referral. The PREA coordinator has been trained as an administrative investigator trainer and provides support and guidance to facility investigators.

Review:
Policy and procedure
Administrative investigator training curriculum
Administrative investigator training certificate
Interview with Associate Director
Interview with PREA Coordinators

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The facility does not offer onsite medical and mental health services. All clients requiring a forensic examination or sexual assault advocate services would be referred to community resources. The facility would use the University of Cincinnati Hospital for SANE practitioners who are available 24 hours a day 7 days a week free of charge. Clients needing mental health services would be first assessed by the facility clinician and then referred out to services in the community. Advocate services for any client needing services after a sexual abuse or sexual assault incident would receive services from Women Helping Women (Women Helping Women offer victim advocate services to men and women).

Review:
Policy and procedure
University Hospital's website
Women Helping Women website
Women Helping Women MOU
Interview with PREA Coordinator
Interview with Case Manger

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All clients are screened within 72 hours from intake to assess their risk of vulnerability or abusiveness. The screening tool used includes all required criteria per the standard to accurately assess the client's risk. The screening is completed by case management staff and a rescreen is completed before the client reaches 30 days in the facility. Case managers have been trained on how to complete the assessment appropriately. Client's assessments are referred to the clinician for further review and/or classification if a client answers in the affirmative to any of the questions. The clinical supervisor also reviews assessments for accuracy. Per policy, a client cannot be disciplined for refusing to answers assessment questions.

Interviews with clients confirmed that they received an assessment at intake and a rescreening at a later date.

Interviews with staff confirmed they understood how to use the screening tool and kept all information confidential. The agency provides case managers with specific PREA training related to their responsibilities as a case manager which includes how to accurately complete an initial assessment and rescreen.

CORRECTIVE ACTION:
The facility's screening tool question as to perception is set up to get the clients perception as to whether others see him/her as being lesbian, gay, transgender, intersex, or gender non-conforming. The FAQ dated October 21, 2016 for this standard clarifies that the determination is based on the screener's perception.

FACILITY RESPONSE:
The screening tool and the procedure have been revised to direct staff to note their perception of the resident's LGBTI status. The Associate Directors have reviewed the new forms and process with case management staff. The auditor has reviewed the new form and meeting minutes.

Review:
Policy and procedure
PREA initial risk assessment
PREA rescreen risk assessment
Interview with case manger
Interview with random clients
New risk assessment forms
Clinical staff meeting minutes

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All clients who receive a classification as vulnerable based on their PREA screening assessment will be housed in a bed/room that provided the maximum supervision. Staff would be aware of their status and ensure the safety and security of the client without knowing details of the assessment.

Besides housing, the information obtained in the assessment may be included in the client's individual case plan. The client and the case manager would create goals to work on while in treatment or the case manager may make community referrals for treatment. Clients could be referred the mental health clinician, Felton Richards, or Deaconess Mental Health Hospital.

The facility has developed an appropriate plan to house transgender/intersex clients safely. The case manager would discuss with a transgender/intersex client all available safety options and allow their views of their own safety to aid in determining housing and treatment options. Clients would be able to receive the same treatment benefits while being house in a manner that allows for safe housing, work, and program assignments.

During the interview, the Associate Director was able to clearly discuss the facility's plan to keep potential victims away from potential abusers during work, education, or program assignments. At this time, the facility does not have a client that has identified as transgender or intersex.

Review:
PREA assessment
Interview with Case Manger
Interview with Associate Director
Interview with PREA Coordinator
Interview with RA staff

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The clients at Cornerstone have multiple ways of reporting sexual abuse or sexual harassment. Posters throughout the facility indicate how clients can report to Talbert House staff as well as how to report to an outside agency. Interviews with the clients indicate that they are aware of all means of reporting and that they could report anonymously. They received the information at intake, during orientation training, and in case manager meetings.

The facility allows for free calls to the reporting entities. Residents are allowed to have cell phones in the facility, which they can use to make a report.

All residents received information at intake and in their handbooks regarding PREA reporting. Staff received information on how to privately report during staff training.

The facility has investigated three allegations of staff sexual misconduct during this audit cycle. Clients reported allegations in two of these incidences.

Review:
PREA postings
PREA brochure
Client PREA education curriculum
Facility tour
Interview with random clients
Interview with random staff
Interview with PREA Coordinator
Investigation reports

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Talbert House has a grievance policy which does not assess a time limit for filing a grievance alleging sexual abuse or sexual harassment. The agency will respond to a grievance within five working days and has several levels of appeals. Should staff need more time to investigate or respond to the client, staff will notify the client of the extension and provide a date a decision will be made. Clients are informed that they are not required to use the grievance system in order to make an allegation of sexual abuse and sexual harassment, and that there are no time limits to reporting. Clients are also notified that third party sources can assist in the grievance process and that they can file a sexual abuse or sexual harassment grievance on behalf of another client. Grievances forms are available to clients and can be returned to any staff member.

During random client interviews, each responded that they were informed of the grievance process at intake. The grievance policy is also outlined in the client handbook which each client has verified they received at intake. No client interviewed has used the grievance system to report an allegation of sexual abuse or sexual harassment. The auditor discussed with the residents response times to any type of grievance and those who have filed various grievances received a response from the agency within the specified time limit.

The facility Associate Director reviewed the grievance process with the auditor and the various levels of appeals available to clients. Clients

who allege substantial risk of imminent sexual abuse will be immediately protected. The victim can be moved to another room or facility or the abuser can be moved to another room or facility. Agency practice is to place any staff member who is the subject of a sexual abuse or sexual harassment allegation on administrative leave.

Review:
Policy and procedure
Interview with random clients
Interview with Associate Director
Interview with PREA Coordinator

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a MOU with Women Helping Women to provide victim advocate services or emotional support services related to sexual abuse. Women Helping Women has provided clients with their address and hotline number in order to obtain these services or make a sexual abuse or sexual harassment report.

The facility informs clients the limits of confidentiality when using these services during orientation group. Staff with licensure also inform clients about the limits of confidentiality when discussing issues with them.

Interviews with clients indicate that they have received the phone number and address of the Women Helping Women and understand that reporting an allegation to the center could result in a mandatory reporting of the allegation. The address and phone number to Women Helping Women is on posters located throughout the facility.

CORRECTIVE ACTION:
The postings throughout the three buildings have the address of the agency listed versus the address of the emotional supportive agency.

FACILITY RESPONSE:
The facility has drafted new postings with the Women Helping Women address listed as a way of contacting an outside emotional supportive agency. The new poster were placed in the three buildings. Auditor review new postings.

Review:
MOU with Women Helping Women
Facility tour
Interview with random clients
Interview with Associate Director
Postings

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has posted on its website ways that anyone can report sexual abuse or sexual harassment on behalf of a resident. Residents are also educated that they can report to family members who can then make a third party report. This information is also on posters located in the visitation room.

The facility has not had a third party report during this audit cycle.

Review:
Agency website
Facility tour
Interviews with random clients

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy that requires all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment, or retaliation, including third party and anonymous reports. The staff have been give instruction on how to document the report in a way which limits access to that information, and to only share that information with staff in order to make treatment, investigation, or other security decisions. All allegations of sexual abuse or harassment are referred to the Associate Director and PREA Coordinator for investigation.

Staff interviewed, including line staff and facility leadership, understood their duty to report and were trained appropriately on the agency's PREA reporting policies. Staff indicated that they would have no trouble reporting any allegation or suspicion of sexual abuse, sexual harassment, or retaliation even if it was against another staff member. The facility has investigated an allegation that was reported based on staff suspicion.

All staff members who have licensure are required to inform clients of their status and the limits of confidentiality. These staff members maintain their duty report any allegation made to them.

The facility does not accept any client that is under the age of 18 and does not have a duty to report to child protective services. The facility would make a report to adult protective services if the alleged victim was classified as a vulnerable adult.

Review:
Policy and procedure
Employee training curriculum
Interviews with random staff
Interview with Associate Director
Interview with PREA Coordinator
Investigation report

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a plan to protect clients from imminent sexual abuse. The facility has several dorm units that a client can be moved to in order to facilitate protection. If necessary, Talbert House has several facilities throughout Cincinnati. The facility could utilize one of the other facilities if necessary to protect a client from imminent sexual abuse. The agency has a practice of placing a staff member on administrative leave if they are the subject of a sexual abuse of sexual harassment investigation.

An interview with the Associate Director and both PREA Coordinators discussed the process for ensuring client safety and making a move to another facility if necessary. The facility has moved a client to another facility during an investigation and has moved a staff member to another facility.

The auditor was left with the impression from the interviews with clients and staff that client safety was paramount to the staff and that any necessary changes that would not jeopardize the safety and security of the facility would be made.

Review:
Police and procedure
Interview with Associate Director
Interview with RA staff
Interview with Case Manger
Interview with PREA Coordinator
Investigation reports

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy that requires the facility Director to report to the head of another facility any allegation made against that facility within 72 hours of receiving the allegation. The Director is responsible for documenting the report and making notification of such report to the PREA Coordinator. Should a report be made to the facility that a client at another facility is making an allegation toward someone in their agency; the Associate Director shall ensure that the allegation is fully investigated.

An interview with the Associate Director indicated that the facility has not received a report from another institution. The facility has made a report to the Montgomery County Jail referring an allegation that was reported to the facility by a client.

Review:
Policy and procedure
Interview with PREA Coordinator
Interview with Associate Director

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy requiring all staff be trained on first responder duties. The duties vary from non-security staff to security staff. All staff are supplied the required first responder training. The facility has a detailed sexual abuse, assault, harassment response procedure for any incident of sexual abuse. This plan is located in the compliance manual stored at the main post. The response procedure includes where to place an alleged abuser when separating from the victim so that the abuse cannot destroy any evidence, preserving evidence until the local legal authority can collect the evidence, requesting that the alleged victim not do anything to destroy evidence including washing, brushing teeth changing clothes, performing bodily functions, smoking, drinking, or eating, reporting allegation to the local authorities and to the facility Associate Director or the manager on call and the PREA Coordinator.

Non-security staff are required per policy to contact a security staff member and make a request that the alleged victim not take any action that could destroy evidence.

During staff interviews, both security and non-security staff have acknowledged their training of the first responder duties. The staff was able to specifically identify the steps they are to take as a security or non-security staff and knew the location of the sexual abuse, assault harassment response procedure.

Review:
Policy and procedure
Facility tour
First Responder Duties in Compliance Manual
Interview with random staff
Interview with Associate Director
Interview with PREA Coordinator

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The agency has developed a Sexual Abuse, Sexual Assault, Sexual Harassment Reporting Form to walk staff members through the coordinated response plan. The plan list the required steps and is posted in the Compliance Manual located at the main post. The steps listed are specific and detailed enough for staff to follow in the event of a sexual abuse/sexual assault incident. The list starts with the first responder duties and refers the staff member to call the local authorities and the Associate Director or Manager on Call as well as the PREA Coordinator.

The Associate Director will follow up with the local authorities until completion of the investigation. An administrative investigation will not take place until after the criminal investigation is completed or in conjunction with the local legal authority.

The staff will offer the victim access to a forensic medical exam at University Hospital, victim advocate services from Women Helping Women, and if the advocate services are not readily available a qualified staff member who has been trained as an emotional support person will assist. The advocate will accompany the victim to the medical exam and any investigative interviews. In cases of sexual assault or sexual abuse, the victim's mental health will be evaluated by the agency clinical supervisor. The clinical supervisor will update the PREA Coordinator on the victim's need for additional services.

The case manager or designee will be responsible for the 90 day retaliation monitoring and status checks.

Review:
Policy and procedure
Sexual abuse, assault, harassment reporting form
Interview with PREA Coordinator
Interview with Associate Director
Interview with staff
Interview with RA Practitioner

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A: The PREA Coordinator reports that the facility does not have a union nor does it enter into any contracts with employees.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The agency has a policy designed to protect clients and staff who report sexual abuse or sexual harassment or cooperate with an investigation from retaliation from other clients or staff. The protection measures include bed moves, dorm moves, facility moves, and administrative leaves for staff. Should a client or staff member make a request, an emotional support person will be available for services.

The Associate Director or designee would be responsible for monitoring the conduct, and treatment of clients or staff who report sexual abuse. The monitoring of clients who report abuse would also include periodic status checks and client disciplinary records, housing, program changes, or negative performance reviews or reassignments of staff. The monitoring would continue past 90 days if need is indicated. Monitoring would cease if the allegation has been determined to be unfounded.

The facility has made facility moves for victims and alleged abusers during investigations in order to protect against retaliation.

The auditor was able to interview the Associate Director as well as the Clinical Supervisor to confirm the retaliation monitoring process and the measures the facility would employ to ensure that a client or staff member would be protected from retaliation.

Review:
Policy and procedure
Retaliation monitoring form
Interview with Associate Director
Interview with PREA Coordinator
Interview with Clinical Supervisor
Investigation reports

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility conducts administrative investigations but does not conduct criminal investigations. Criminal investigations would be completed by City of Cincinnati Police Department. The facility has three allegations of staff sexual misconduct during this audit cycle.

Investigation #1: A client made a sexual abuse allegation against a staff member. The allegation was referred to the Cincinnati Police Department for criminal investigation and an internal administrative investigation also took place. The administrative investigation determined that the allegation was not founded. The police department determined there was no criminal activity. During the investigation, the clients was moved to another halfway house facility and a rescreen was conducted.

Investigation #2: A staff member made a suspicion report on an inappropriate relationship between a staff member and client. The facility conducted an administrative investigation and referred the allegation to the Cincinnati Police Department. Both investigation determined the allegation to be unfounded. During the investigation, the staff member was transferred to another facility and the client received a risk assessment rescreen. After the investigation was complete, staff was retrained on who to manage rumors and when it is appropriate to intervene in situations.

Investigation #3: A client made a retaliation report against a staff member claiming he was be retaliated against because he ended the relationship with staff. The client would not provide any evidence to his claim. The Bureau of Prisons also investigated allegation. The allegation was determined to be unsubstantiated. The client is no longer at the facility due to an escape charge.

The facility has a trained administrative investigator and the PREA Coordinator is a trained investigator as well.

The auditor sat with the PREA Coordinator and the PREA Investigator to review the process for how the investigator completes an investigation. The investigator discussed the review of any camera footage if available, interviewing the alleged victim, witness, and abuser, and review if there has been previous complains made against the suspected abuser. At no time does the investigator use status as a client or staff member to determine credibility. The facility does not use a polygraph examination as part of an administrative investigation. All allegations will receive an administrative investigation regardless of whether the alleged victim or abuser is no longer employed or in the control of the agency.

All allegations are documented and reviewed by the Risk Management Committee. The report is comprehensive in the information it collects from the beginning to the disposition of the allegation. If a Sexual Abuse Review Team meeting and retaliation monitoring is necessary, the investigator will denote the time of the SART meeting and who is responsible for retaliation monitoring.

The PREA Coordinator confirmed the retention schedule of for as long as the person is incarcerated or employed with the agency plus five years. The Associate Director is responsible for maintaining contact with the legal local authority when the investigation has been referred for criminal investigation.

Review:
Policy and procedure
Investigation reports
Interview with PREA Coordinator
Interview with Associate Director
Investigation reports

Standard 115.272 Evidentiary standard for administrative investigations

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

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

By agency policy and confirmed by the investigator and PREA Coordinator interviews, the agency imposes a standard of preponderance of evidence or 51% to substantiate an allegation of sexual abuse or sexual harassment.

The PREA Coordinator reviews all investigations to ensure that the proper determination was met based on the preponderance of evidence criteria.

Review:
Policy and procedure
Interview with PREA Coordinator

Standard 115.273 Reporting to residents

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

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

Talbert House policy requires client notification to any client that alleges sexual abuse or sexual harassment whether that allegation has been determined to be substantiated, unsubstantiated, or unfounded. The PREA coordinator is responsible for reporting investigation outcomes to clients.

Review:
Policy and procedure
Client notification
Investigation reports
Interview with PREA Coordinator

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Talbert House outlines its progressive disciplinary plan in its employee handbook. A review of the handbook states that any staff member found to have engaged in sexual abuse will be terminated. Termination or resignations by staff will not void an investigation and any criminal activity will be reported to the legal authority and to any relevant licensing agency. Policy also indicates that the agency will notify law enforcement or any relevant licensing boards of any terminations or resignations based upon violations of the agency's client sexual abuse and sexual harassment prevention policy when such behavior is criminal in nature.

All staff interviewed understood that anyone engaging in sexual harassment will be disciplined according to agency policy and that they would be terminated for participating in sexual abuse. Staff indicated that they are required to report any suspicion to their immediate supervisor and that they would not have any issue reporting a coworker for violation of the zero tolerance policy.

The auditor reviewed agency policy, the employee handbook, and interviewed the PREA Coordinator and Human Resource Generalist to confirm the disciplinary process for employees found to have substantially engaged in sexual harassment or sexual abuse against residents. All agency leadership stated that any employee found to have engaged in sexual harassment will be immediately disciplined up to and including termination from the facility and employees found to have engaged in sexual abuse will be immediately terminated and law enforcement would be notified.

Review:
Policy and procedure
Employee handbook
Interview with random staff
Interview with PREA Coordinator
Interview with Human Resource Generalist
Review of employee files

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All contractors and volunteers are made aware of the agency's zero tolerance policy toward sexual abuse and sexual harassment. Each must participate in PREA training where they will be taught how to prevent, detect, respond, and report sexual harassment and sexual abuse.

The facility has not had an allegation of sexual abuse or sexual harassment against a contractor or volunteer during this audit cycle.

Review:
Policy and procedure
Contractor training verification
Interview with PREA Coordinator
Investigation reports

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has an appropriate policy that disciplines clients for a substantiated allegation of sexual abuse or sexual harassment or for a criminal finding of guilt for sexual abuse or harassment. The facility has not had an allegation of client on client sexual abuse or sexual harassment, nor have they had a guilty finding in a criminal investigation of client on client sexual abuse or sexual harassment during this audit cycle.

The client handbook clearly defines the agency's rule violations and the possible sanctions. Each client is given a handbook at intake and staff reviews the handbook, specifically the disciplinary policies, with each client.

During client interviews, all clients stated that they received a handbook at intake and that staff reviewed the disciplinary policies with them. Each client was able to identify the sanctions that accompany a substantiated allegation of sexual abuse or sexual harassment or a criminal finding of guilt.

Review:
Policy and procedure
Client handbook
Interviews with random clients
Interview with PREA Coordinator

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

After an incident of sexual abuse or sexual assault, victims are offered unimpeded access to emergency medical treatment and crisis intervention services. Qualified practitioners who would determine the appropriate scope of services would provide these services. Medical services would be provided by University Hospital, and mental health, crisis intervention, or advocacy services would be provided by Women Helping Women. Clients would be given timely information about sexually transmitted infections prophylaxis (there are no women in this facility). All services are offered free of charge to clients.

The victim's mental health will be evaluated by the agency clinical staff. The clinician will update the PREA Coordinator on the victim's need for outside services.

Talbert House staff are trained on the appropriate response to an incident of sexual abuse or sexual assault during monthly staff meetings.

A review of allegation investigation forms shows that staff would offer clients the opportunity to receive medical and mental health care if appropriate.

Review:
Policy and procedure
Sexual Abuse, Assault, Harassment Reporting form
Training roster
Investigation report form
Interview with PREA Coordinator
Interview with Associate Director
Interview with random staff

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility offers community medical and counseling services for clients who have been sexually abused in a prison, jail, lockup, or juvenile facility. The treatment includes testing for sexually transmitted diseases. Treatment is offered to all known client to client abusers within 60 days of learning such history. All treatment is offered free of charge. The facility has not had a report of any known client to client abuser.

Staff are trained on the first responder duties and coordinated response plan. This plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. Ongoing medical and mental health care will be at the discretion of the medical provider and is again at no cost to the resident.

The PREA initial screening and rescreening along with other intake documentation are reviewed to determine if a client has abused others while in a correctional setting. If a client indicates or has a report that indicates that he has in fact abused another client while in a correctional setting, the agency's clinician would meet with the client to determine if additional treatment or a referral for community treatment is necessary.

Review:
Policy and procedure
Sexual Abuse, Assault, Harassment Reporting form
MOU with Women Helping Women
Training roster
Interview with PREA Coordinator
Interview with Associate Director
Interview with random staff

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Talbert House has an agency policy on a review of all substantiated or unsubstantiated allegations of sexual abuse within 30 days of the conclusion of the investigation. The review team includes the PREA Coordinator, Facility Associate Director, Facility Director, Clinical staff, and any other staff member deemed necessary.

The team would review agency policies and practices, training, staffing plan, and physical vulnerabilities. This includes whether a change in policy or practice will better prevent, detect, or respond to sexual abuse; if the incident or allegation was motivated by race, ethnicity, gender identity, gang affiliation, or any other group dynamic; if any physical barriers in the area enabled the abuse; adequacy of staffing levels; and whether monitoring technology should be deployed or augmented to supplement supervision by staff. The agency's Risk Management Committee will review for any significant issues that may need to be addressed agency wide.

Cornerstone has had two allegations required a SART review; however, the facility completed a review on all allegations. The auditor review the paper work and process of a SART review with the PREA Coordinator. The SART team determined that additional training for staff was necessary during one of the reviews. The Director ensured that the Associate Director implemented any recommendations.

Review:
Policy and procedure
SART review forms
Interview with PREA Coordinator
Interview with Associate Director
Investigation reports

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility directors are responsible for collecting the data for every allegation of sexual abuse and sexual harassment at the facility for each calendar year. The facility is using Ohio Department of Rehabilitation and Corrections PREA reporting form as the collection instrument. The information from this report is aggregated and listed in the agency's annual PREA report and the report is posted on the facility's website.

The PREA Coordinator reports the records retention schedule for information collected is ten years.

The Justice Department has not requested this information from the agency.

Review:
Policy and procedure
Annual PREA report
Agency website (http://www.talberthouse.org/resources/prea-5/)
ODRC PREA outcome measures report
Interview with PREA Coordinator

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy requiring the PREA Coordinator to publish an annual PREA report. The report contains details on how the facility assess and improves the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. The report identifies problem areas and corrective action along with the corrections from prior years. The report also includes an assessment of the agency's progress in addressing sexual abuse.

A review of the report shows the facility documented the required information as well as a comparison to last year's allegation demographics and corrective actions. The report list the ways the agency has addressed issues and its overall progress toward addressing sexual abuse.

The report is posted on the agency's website (http://www.talberthouse.org/resources/prea-5/) and includes reports from previous years. The report does not include any identifying information that could jeopardize the safety and security of the facility.

Review:
Policy and procedure
Annual PREA report

Interview with PREA Coordinator

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Coordinator is responsible for the collection and secure retention of all data collected pursuant to standard 115.287. The data collected will be retained to 10 years. The Coordinator takes all collected information from each facility under the Talbert House Inc. umbrella and creates an annual report which is published on the agency's website (http://www.talberthouse.org/resources/prea-5/) after approval from the agency's President/CEO.

The report does not contain any information that could identify anyone personally or contain any information that could jeopardize the safety and security of the facilities.

Review:
Policy and procedure
Annual PREA report
Agency website
Interview with PREA Coordinator

AUDITOR CERTIFICATION
I certify that:

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

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

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

Kayleen Murray October 18, 2017

Auditor Signature Date