PREA AUDIT REPORT ☐ Interim ☒ Final
COMMUNITY CONFINEMENT FACILITIES

Date of report: December 21, 2016

Auditor Information			
Auditor name: Joseph Rion			
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Date of facility visit: June 27, 2016			
Facility Information			
Facility name: Keeton Corrections, Inc., Mobile Community Services Center			
Facility physical address: 4901 Battleship Parkway, Spanish Fort, Alabama 36725			
Facility mailing address: *(if different from above)* same as above			
Facility telephone number: 352-368-2127			
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: Lucy May, Director			
Number of staff assigned to the facility in the last 12 months: 38			
Designed facility capacity: 58			
Current population of facility: 58			
Facility security levels/inmate custody levels: Minimum/Community			
Age range of the population: 21-66			
Name of PREA Compliance Manager: Lucy May		**Title:** Facility Director	
Email address: kcimobile@keetoncorrections.com		**Telephone number:** 251-626-5094	
Agency Information			
Name of agency: Keeton Corrections, Inc.			
Governing authority or parent agency: *(if applicable)* same as above			
Physical address: 213 Harrison Avenue, Panama City, FL 32401			
Mailing address: *(if different from above)* same as above			
Telephone number: 850-747-8776			
Agency Chief Executive Officer			
Name: Kimberly Spence		**Title:** President	
Email address: ceokks@keetoncorrections.com		**Telephone number:** 850-747-8776	
Agency-Wide PREA Coordinator			
Name: Terracina Davis		**Title:** Quality Assurance Manager	
Email address: kciqa@keetoncorrections.com		**Telephone number:** 850-747-8776	

AUDIT FINDINGS

NARRATIVE

The on-site portion of the Prison Rape Elimination Act (PREA) audit of the Mobile Community Services Center was conducted on June 27, 2016. The facility is also commonly known as Keeton Corrections, Inc. at Mobile. The Mobile Community Services Center is owned and operated by Keeton Corrections, Inc. For purposes of the audit, "agency" refers to Keeton Corrections, Inc. and "facility" refers to the Mobile Community Services Center. The facility is considered a community confinement facility.
The audit was conducted by Joseph Rion, a United States Department of Justice certified auditor. Mr. Rion is certified to conduct audits of adult prisons, jails, lock-ups, and community confinement facilities.

Proir to the on-site portion of the audit, materials and data provided by the facility were reviewed. Materials reviewed included applicable agency policies, applicable BOP policies, facility statement of work (contract with federal customer), organizational charts, facility staffing pattern, facilty employee roster, resident education materials, staff training curriculum, facility mission statement, the intake risk assessment screening form, the facility floor plan diagram, and the completed pre-audit questionnaire. The on-site porion of the audit provided an opportunity for the auditor to verify the information contained in the pre-audit questionnaire.

During the on-site portion of the audit, a variety of techniques were utilized to assess the compliance levels of the standards. Although a thorough review of applicable policies and procedures was an essiential component of the audit procees, much of the focus of the on-site portion of the audit was to verify the practices mandated by the standards. To the extent possible, each component of each statndard was verified by multiple sources. A variety of verification methods were utilized toward this end. On-site random document reviews were conducted as one means of practice verification. Six resident case files were randomly selected by the auditor to ensure residents had received PREA educational materials during the intake process. Each resident file contained the appropriate documentation. The population of the facility was 58 on the day of the audit. The selection of six resident case files represented a sample size of approximately 10% of the facility population. The auditor viewed the sample size to be large enough to be representative of the population from which the files were drawn. The size of the sample coupled with a random method of selection were deemed to be sufficient to enable the auditor to draw reasonably valid inferences which could be extrapolated from the cases sampled to the entire population from which the sample files were drawn. The facility census roster was the source document from which the residents were selected.
Six resident case files were also randomly reviewed to verify that intake sceening forms were being completed timely and consistently. The six resident case files were randomly selected by the auditor from the census roster. Each of the three files contained the appropriate documentation. The sample size of six resident files represented 10% of the resident population and was considered to be a large enough sample that information contained within the files could be extrapolated to the population from which they were drawn. Additionally, six staff personnel files were randomly selected from the staff roster to ensure staff had completed the required training in PREA-related topics. Each selected staff personnel file contained the appropriate documentation that the required training had been received. The sample size of six staff personnel files represented 23% of the total number of employees. Six additional staff personnel files were reviewed to ensure the staff had undergone background checks prior to being hired into positions requiring contact with residents. Each personnel file contained the appropriate documentation. In the opinion of the auditor, the sample size of of six staff personnel files was sufficiently large that the information within the files could be validly extrapolated to the entire population from which they were drawn. Other verification methods employed by the auditor included random and targeted interviews of both staff and residents utilizing pre-established interview protocols and the on-site observations of the auditor.

A brief introductory meeting was conducted at the facility during the morning of June 27, 2016. Attendees included Joseph Rion, auditor; Byron Jasis, Assitant Director, Keeton Corrections-Paducah and Lucy May, Facility Director, Mobile Community Services Center. Mr. Jasis was heaviliy involved in drafting and implementing Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA. This policy sets forth agency-level PREA guidelines and serves as one of the primary mechanisms for the implementation of the PREA standards. Mr. Jasis assisted facility staff in preparing for the PREA audit and was available to answer questions concerning the PREA policy and its implementation or other related operational issues. Mr. Jasis also served as a liaison to the Keeton Corrections corporate office. During the meeting, the audit schedule was reviewed and the auditor presented a brief overview of the audit process including the applicable time frames for the compilation, review, and submission of the interim and final reports.

Ms. May and Mr. Jasis escorted the auditor on a tour of the facility. Inside areas visited included the male dormitory, the female dormitory, the multi-purpose room, the administrative office area, the monitor station, and the lobby. Outside areas visited included the parking area and the outside area adjacent to the facility. During the course of the tour, the auditor had the opportunity to ask questions and informally interact with the residents and staff encountered during the course of the tour. The auditor observed the audit notice poster containing the auditor contact information had been prominently posted in various parts of the facility with copies having been posted in both dormitories, the lobby area, the multi-purpose room, and inside the monitor station. The poster had been provided to the facility approximately seven weeks prior to the audit date and was posted within the required six week time frame. The auditor did not receive any pre-audit correspondence as a result of the posted notice. Both dormitories utilized open-bay barracks style bed configurations which provided each resident with an assigned bed and storage locker within a single open dormitory room. The restroom and shower areas were adjacent to the main living areas but only the entry way to these areas were in view from the main living area. The showers were located in single stalls which were equipped with privacy curtains. Additionally, the toilet areas were separated by privacy curtains. The facility maintains a PREA hotline which may be used to report sexual abuse to an outside entity not affiliated with the agency. Educational posters containing

the zero tolorence policy and the PREA hotline phone number were posted throughout the facility in both dormitories, the multi-purpose room, and the lobby.

A significant portion of the on-site portion of the audit was spent conducting formal interviews with facility staff and residents. A total of ten staff members members were interviewed. The staff interviews included eight facility staff representing approximately 30% of the staff complement. Two agency-level staff members were also interviewed. Mr. Jasis provided information regarding policy and operational issues on an on-going basis. Facility staff included representatives from each shift (8:00 a.m. to 4:00 p.m., 4:00 p.m. to 12:00 a.m., and 12:00 a.m. to 8:00 a.m.). At the facility level, staff responsible for first-responder duties, general supervision of residents, intake processing, and counseling services were included. Random staff chosen for interviews were selected from the group of on-duty staff as reflected on the staff roster. The auditor utilized a method of random selection beased on the beginning letter of the staff member's last name. There were two agency-level staff interviewed. The Vice President of Operations was interviewed via telephone. Terracina Davis, agency-level Quality Assurance Manager and PREA Coordinator was also interviewed during a separate telephone interview. The facility does not utilize medical staff, contractors, or volunteers as service providers so representatives from these groups were not included in the interview process. There were eight residents interviewed representing approximately 14% of the population. The resident interview group included six male residents and two female residents. The male residents chosen for interviews were selected by the auditor from the census roster. The auditor utilized a method of random selection based on the beginning letter of the resident's last name or the beginning letter of the resident's first name. There were only two female residents on-site at the time of the audit and both were interviewed.

DESCRIPTION OF FACILITY CHARACTERISTICS

Keeton Corrections, Inc. is a private for profit mid-sized provider of residentional correctional services based in Panama City, Florida. The company operates residential facilities in Florida, Alabama, and Kentucky. The Mobile Community Services Center is owned and operated by Keeton Corrections, Inc. The stated mission of Keeton Corrections, Inc. is "to assist individuals in any phase of the correctional system in finding, and maintaining suitable employment, resolving personal difficulties, defining and/or establishing healthy peer and family relationships, and planning for a successful reintegration into society." The mission goals are " to operate clean and safe facilities that provide a high degree of accountability for the safety of our staff, our residents and our community; to maintain a leadership role in the field of private community corrections programs; to continually update and introduce new technological advances in the field of community corrections management; to find innovative solutions for quality enhancement of programs and services provided to contract sources; to seek ancillary contracts at all facility sites which can supplement our revenue-producing potential; to pursue new facility contracts which meet our size and geographic requirements for quality and profitability; to ensure that all facilities, programs, services, and personnel meet or exceed community correctional standards; and to forge strong relationships with local law enforcement and community groups in each of our host communities."

The Mobile Community Services Center provides residential halfway house services pursuant to a contractual arrangement with the Federal Bureau of Prisons (BOP). The facility is designated as a residential re-entry center that houses low- risk, short-term offenders. The facility serves as a transitional step down facility for residents who have been received in transfer from a BOP facility and are nearing the end of their sentence. The facility also houses residents who have been granted probation or are otherwise under the supervision of the federal courts. These inmates are housed at the facility as a condition of supervision. All facility residents are classified as miniumum custody offenders suitable for placement in community level custody. Most residents housed at the facility have six months or less to serve. A variety of programming opportunities are available with an emphahsis on employment skills and placement. Residents in need of specialized programming such as substance abuse counseling can participate in off-site programs as deemed appropriate for their needs. Some residents will transition from placement at the facility to home incarceration where a variety of monitoring techniques such as telephone verification and the use electronic monitoring via ankle bracelets are utilized. There are no industires programs in place at the facility.

The total facilty design capacity is 58 which includes 50 male beds and eight female beds. On the day of the audit the population census count was 58. The population was comprised of 52 male residents and six female residents. The average daily population for the 12 months preceeeding the audit was 53 (does not include residents on home incarceration who are also carried on the facility roster).

Pedestrian traffic entering and exiting the facility is controlled by staff assigned to the monitor station. The monitor station is located off the lobby area which serves as the entry way into the facility. Pedestrian traffic is recorded by a sign-in and sign-out log maintained at the station. The monitoring station serves as the central control center for the facility.

The physical plant of the facility is comprised of one main building which contains one male and one female dormitory. The dormitories utilize an open-bay barracks style bed configuration. Each dormitory contains at least one emergency egress door within the living quarters. These doors are equipped with an an alarm system which will alert in the monitoring station when the door is opened. The staffing pattern of the facility requires a minmum one male staff member to be on duty at all times with each dormitory being supervised by a staff member of the same gender as the residents assigned to the dormitory. The assigned staff members are titled as "monitors" and are stationed inside the dormitories in order to provide direct supervision of the residents within their assigned housing areas. Anytime a staff member of the opposite gender enters either of the dormitories a "knock and announce" system is utilized. Additionally, opposite gender staff will announce their presence prior to entering the restroom/shower areas. The auditor observed these systems in use during the course of the facility tour. The phyisal plant also incudes a multi-purpose room utilized for visitation, group meetings and leisure time activities, an administraitive office section, the monitoring station, a lobby area, and an outdoor parking area.
The facility has six surveillance camaras which may be viewed from the monitor station. The cameras are utilized to provide on-going surveillance of key areas of the facility such as the multi-purpose room, hallways, lobby, and the outside of the facility. Cameras are not utilized in the dormitory or restroom/shower areas due to the expectation of privacy in these areas.

The facility does not employ medical staff. Emergency medical services are available by means of the local Emergency Medical Services (EMS). Residents requiring emergency medical treatment may be transported to local hospitals within the USA Children and Women's Hospital. Facility residents must meet designated medical standards to qualify for placement at the facility. The facility has an informal agreement with the Baldwin County Sheriff's Office to investigate allegations of sexual abuse.

SUMMARY OF AUDIT FINDINGS

The facility reported that in the past year there were zero allegations of sexual abuse, sexual harassment, or retaliation for reporting instances of sexual abuse or sexual harassment. Accordingly, there were no investigations relating to sexual abuse, sexual harassment, or retaliation for reporting instances of sexual abuse or sexual harassment. All of the residents interviewed were aware of their rights to be free from sexual abuse, sexual harassment, and retaliation. The majority were familiar with the various reporting mechanisms and available services. All of the staff that were interviewed were familiar with the zero tolerance policies relating to sexual abuse, sexual harassment, and retaliation and knew their rights and responsibilities in regard to the policies. The staff were well versed in their duties and obligations regarding maintaining zero tolerance for sexual abuse, sexual harassment and retaliation for reporting sexual abuse and harassment. It was apparent to the auditor that both the facility and agency had put a substantial amount of resources into implementing the PREA standards. Although there were a number of standards that were non-compliant at the time of the audit, in most cases there had been significant progress made toward full compliance with the standard. In many cases, the non-compliance finding was based on the failure to demonstarate compliance with only one or two componenets of the standard. In these cases, the corrective action required to bring the standard into full compliance may be minimal. In general, the facility has made great strides toward the implementation of the PREA standards.

December 21, 2016 Update Since the Audit-Corrective Action Taken by the Mobile Community Services Center to Achieve Full Compliance:

The Interim Compliance Report reflected that there were 16 standards that were in non-compliance at the conclusion of the audit. The on-site portion of the audit was conducted on June 27, 2016 triggering a 180 day corrective action period beginning on July 27, 2016. The auditor recommended a corrective action plan for the facility and the agency administrative staff agreed. Corrective action efforts were initiated upon receipt of the interim report on July 27, 2016. Documentation demonstrating compliance with the corrective action plan were submitted to the auditor as each corrective action item was completed. All requested documentation had been submitted to the auditor and reviewed by December 21, 2016. On December 21, 2016 the auditor determined that the Mobile Community Services Center had fully implemented the corrective action plan and had demonstrated compliance with 100% of the applicable standards.

Compliance Tally Following the On-site Audit:	Compliance Tally After Completion of Corrective Action:
Number of standards exceeded: 0	Number of standards exceeded: 0
Number of standards met: 16	Number of standards met: 36
Number of standards not met: 20	Number of standards not met: 0
Number of standards not applicable: 3	Number of standards not applicable: 3

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.

This standard requires the promulgation of a policy of zero tolerance for sexual abuse and sexual harass ment and the appointment of an agency-level PREA coordinator. The Mobile Community Services Center has a zero tolerance of sexual abuse and sexual harassment which is outlined in Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA. The policy is comprehensive in scope and addresses key policy components such as definitions, prohibited conduct, staff training, resident education, resident risk as sessment and monitoring, resident and staff reporting procedures, retaliation, investigations, first responder duties, and incident review procedures.

Keeton Corrections, Inc. has an assigned agency-level PREA Coordinator. Ms. Terracina Davis, Quality Assurance Manager for Keeton Corrections, Inc. serves as the agency PREA Coordinator. In this capacity Ms. Davis is responsible for coordinating the PREA efforts throughout all of the facilities owned and operated by Keeton Corrections, Inc. Specific duties include assisting in the development and implementation of PREA policies, conducting staff training in PREA issues, and providing technical assistance and guideance to field staff regarding PREA issues. Ms. Davis reports to Karen Hall, Vice President/Operations. Ms. Davis indicated she has sufficient time and authority to develop, implement, and oversee the agency efforts toward PREA compliance. Interviews and discussion with administrative staff at both the agency and facility level reaffirirmed that successful implementation of the PREA standards is a top-priority goal of Keeton Corrections, Inc. Based on interviews and discussions with administrative staff members and a review of the applicable policies and practices, it is apparent that the facility has put a great deal of effort into devolping and implementing the PREA standards.

Policy, Materials, Interviews and Other Evidenc Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 1, pp. 1-12.
(2) Mobile- Statement of Work, p. 20 (contractor shall comply with P.S. 5324, Sexually Abusive Behavior Prevention and Intervention Program).
(3) Mobile-Statement of Work, pp. 20-21, (contractor shall comply with the Prison Rape Elimination Act (PREA).
(4) Letter from Dana Digiacomo to Kimberly Spence dated February 29, 2016 (contractors shall comply with PREA standards).
(5) Keeton Corrections Organizational Chart-2016.
(6) Auditor Notes- Interview with Terracina Davis, Quality Assurance Manager (agency-level) & Agency PREA Coordinator.
(7) Auditor Notes-Interview with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.
(8) Auditor Notes-Interview with Lucy May, Facility Director.
(9) Pre-Audit Questionnaire, Mobile Community Services Center.

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.

This standard addresses contracting with other entities for the confinement of residents. This standard is not applicable to Mobile Community Services Center. The Mobile Community Services Center is a private, contracted residential service provider for the U.S. Bureau of Prisons. It does not subcontract with any other entity to house or confine any of its residents. This was confirmed through interviews with administrative staff.

Policy, Materials, Interviews, and Other Evidenc Reviewed:

(1) Mobile-Statement of Work, p. 7 (service contract with the BOP limits the contractor's use of subcontractors to fulfill the terms of the contract).
(2) Auditor Notes-Interview with Terracina Davis, Quality Assurance Manager (agency level) and Agency PREA Coordinator.
(3) Auditor Notes-Interview with Lucy May, Facility Director.
(4) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard requires the devopment of a staffing plan that considers the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and any other relevant factors. The staffing plan must be reviewed as needed or at least least annually. Deviations from the staffing plan must be documented. When the staffing plan is reviewed the facility must assess, determine, and document whether adjustments are needed to the staffing plan, the prevailing staffing patterns, the deployment of video monitoring or other monitoring techniques, and the resources the facility has available to commit to ensure adequate staffing levels. Under the terms of the contract with the Federal Bureau of Prisons, the facility will maintain a minimum of two staff members (one male and one female) on-site on a 24 hour per day, seven day per week basis. The entire contract is reviewed by facility, agency and Federal Bureau of Prisons staff at least annually or as the need arises. Additionally, staff from the Federal Bureau of Prisons conduct a minimum of three scheduled and one unscheduled on-site monitoring visits per year. The staffing pattern is one of the components that is reviewed during each monitoring visit. The facility currently maintains six surveillance cameras which cover all areas of the facility except the dormitory living areas and the adjacent restroom/shower areas. The deployment of cameras and other appropriate technology is reviewed at least annually as part of an annual review of the IT systems conducted at the agency level. This was confirmed during interviews and discussion with upper level administrative staff at both the facility and agency level. Although there is ample evidence the staffing plan is reviewed frequently, there is no documentation that the criteria listed in (a), (1)-(4) of Standard 115.213 were considered when the plan was developed. Additionally, interviews and discussions with facility-level and agency-level administrative staff confirmed that there was no formal mechanism under which the staffing plan is annually reviewed taking into account the factors listed in (c), (1)-(4) of Standard 115.213. The agency/facility should establish and document a formal process to review the staffing plan to comply with the requirements of this standard.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Facility Staffing Pattern.
(2) Facility Work Roster.
(3) Physical Plant Schematic Diagram.
(4) Mobile- Statement of Work, p. 1 (demonstrates annual contract reviews), p.10 (staffing pattern requirements).
(5) Auditor Notes-Interview with Lucy May, Facility Director.
(6) Auditor Notes-Interview with Karen Hall, Vice President/Operations.
(7) Auditor Notes-Interview with Terracina Davis, Quality Assurance Manager (agency level) and Agency PREA Coordinator.

Corrective Action Required:

(1) Document that the existing staffing plan has been reviewed based on the factors listed in (a), (1)-(4) of Standard 115.213.
(2) Revise the PREA policy to add language that the staffing plan shall be reviewed as needed but at least annually and the review shall consider the factors listed in (c), (1)-(4) of Standard 115.213.
(3) Train staff on the revised policy and document the training.
(4) Document the annual reviews in some retrieveable form such as generation of a report or keeping minutes of the review meeting.

(1)Plan of Corrective Action/Deliverables:
(A)Assigned Staff-Byron Jasis and Facility Director
(B) Task- Document that the existing staffing plan has been reviewed based on the factors listed in (a), (1)-(4) of Standard 115.213.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 19, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016. The memorandum documented that the staffing plan had been been reviewed in accordance with Section (a) items (1)-(4) of Standard 115.113. The facility is now in compliance with this compnenet of the standard and the standard in general.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Memorandum from Lucy May documenting the review of the staffing plan dated December 1, 2016.

(2) Plan of Corrective Action/ Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy to add language that the staffing plan shall be reviewed as needed but at least annually and the review shall consider the factors listed in (c), (1)-(4) of Standard 115.213.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 2, Personnel. The policy contained language requiring the staffing plan to be reviewed at least annually taking into consideration the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse and other relevant factors. The facility is now compliant with this component of the standard and the standard in general.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 2, Personnel (revised) at page 1.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Facility Director.
(B) Task-Train staff on the revised policies and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016. The memorandum documented that all staff had been trained in the revisions to Keeton Corrections Policy and Procedure 2, Personnel. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting that staff had been trained on the revised PREA policy.

(4) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Facility Director.
(B) Task-Document the annual reviews in a retrievable form such as a report or minutes.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 19, 2016 the auditor reviewed a copy of a memorandum from Lucy May dated December 1, 2016 which verified that the

staffing plan had been reviewed in accordance with the requirements outlined in (a), (1)-(4) of Standard 115.213. This information has been documented in memorandum form. The facility is now in compliance with this component of the standard and the standard in general.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting that the staffing plan had been reviewed in accordance with (a), (1)-(4) of Standard 115.213.

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.

This standard prohibits cross-gender pat-searches, strip searchs, and visual body cavity searches except in exigent circumstances or when performed by medical practitioners. Facilities may not restrict female residents access to regularly available programming or other outside opportunities to comply with the standard. Facilities shall document all cross-gender strip searches, visual body cavity searches, and pat-down searches of female residents conducted by male staff. Residents shall be permitted an opportunity to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitilia except in exigent circumstances or when such viewing is incidental to routine cell checks. Transgender or intersex residents shall not be subjected to a physical examination of their anatomy for the sole purpose of determiniong the resident's genital status. Security staff shall be trained in appropriate methods of conducting cross-gender pat-down searches and how to search transgender and intersex residents. Under the agency search policy, pat-down searches must be conducted by staff members of the same gender as the resident being searched unless exigent circumstances exist. Body cavity searches are not permitted on facility grounds. The search policy does not specifically address the guidelines for conducting resident strip searches. During the course of interviews and discussions with administrative staff, it was explained that the current practice was to not conduct resident strip searches. There are plans to add language to this effect to the search policy. The facility indicated that during the preceding 12 month period there were no instances in which cross-gender strip searches, visual body cavity searches, or male to female pat-searches occurred. Administrative staff indicated that should any searches of this nature occur in the future, they would be documented. The PREA policy requires that residents be permitted to shower, perform bodily functions and change clothing without being viewed by staff of the opposite gender unless exigent circumstances exist. The auditor observed that measures to ensure the privacy of residents were in place. The cameras were not positioned in a manner to view residents within the dormitories. Privacy curtains were in place in the shower/restroom areas. The staffing plan requires that one male and one female staff be on duty at all times. In the event there are not both a male and female staff on duty, a hand-held metal detector may be utilized which does not require the staff member to make physical contact with the resident. Staff are prohibited from physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.

Residents are supervised within the dormitories by staff of the same gender. In the event a staff member of the opposite gender enters the living area or the restroom/shower area, a "knock and announce" system is utilized. Although the "knock and announce" system was in place and working effectively, there was no provision in the PREA policy that this system was a mandatory requirement. Policy language

addressing the "knock and announce" systems should be added to the PREA policy to comply with the requirements of the standard. The surveillance cameras are not positioned to view the dormitory living areas or the restroom/shower areas.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, (E.), (1.), p. 6.
(2) Keeton Corrections Policy and Procedure 9, Searches and Contraband, (A.), (1)-(4), pp. 1-2.
(2) Mobile-Statement of Work, pp. 69-70 (contractor required to adopt search policy and train staff in policy provisions and how to conduct searches).
(3) Auditor Observation-Camera Placement.
(4) Auditor Observation-"knock and announce" system during tour.
(5) Auditor Notes-Interview with Lucy May, Facility Director.
(6) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.
(7) Auditor Random Staff Interviews (confirming search practices and knock and announce system, 8 of 8 facility staff confirmed).
(8) Auditor Random Resident Interviews (confirming search practices and "knock and announce" system, 8 of 8 residents confirmed).

Corrective Action Required:
(1) Add specific policy language to Keeton Corrections Policy 22, Sexual Abuse and Assault and PREA, that includes the reqirement that the "knock and announce" procedure be followed when staff of the opposite gender enter the dormitory or restroom/shower areas of residents of the opposite gender.
(2) Add policy language to Keeton Corrections Policy and Procedure 9, Searches and Contraband, that addresses resident strip searches.
(3) Conduct and document staff training on the revised policies.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task-Add specific policy language to the PREA policy that requires staff to follow the "knock and announce" system when entering the living quarters of residents of the opposite gender.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language requiring staff to follow the "knock and announce" system when they enter the living quarters of residents of the opposite gender was added to the policy. The facility is now in compliance with this componenet of the standard and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Proceedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 4.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task-Add policy language to Keeton Corrections Policy and Procedure 9, Searches and Contraband, that addresses resident strip searches.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Proceedure 9.1, Searches and Contraband. Language has been added to the policy addressing strip searches and body cavity searches. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 9.1, Searches and Contraband (revised) at page 1.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task-conduct and document staff training in the revised policies.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016. The memorandum documented that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

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.

This standard requires that residents with physical, intellectual, psychiatric or speech disabilities have equal opportunity to participate in or benefit from all aspects of agency efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility reports that there have been no cases within the past year in which a resident was received with physical, intellectual or speech disabilities. In the event a resident with special needs of this type is received, the facility is authorized to take corrective measures to ensure that the resident can effectively communicate with staff. Such meaures include but are not limited to purchasing special equipment such as a hearing aide or telephone amplification device. In interviews and discussions with administrative staff, it was explained that corrective measures would be individualized based on the specific needs of the resident. The PREA pamphlets are written in both English and Spanish. In the event a resident has language proficiency issues in another language, the facility has the ability to enlist the services of an interpretor if needed. During interviews with administrative staff it was explained that there are a number of providers in the local area that can serve as interpretors. It is recommended that the facility maintain a list of service providers who would be willing to provide interpretor services should the need arise. Other residents will not be utilized for this purpose except in circumstances where extended delays would compromise the safety of the resident. This was confirmed during the course of interviews and discussions with administrative staff.

Policy, Materials, Interviews and Other Evicence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, (3.), p. 6.
(2) Mobile Statement of Work, pp. 8-9 (contractor will provide for translation of facility rules, emergency diagrams and other related documents into a foreign language as required by the composition of the offender population).
(3) PREA Handout Materials-Spanish Version.
(4) Auditor Notes-Interview with Karen Hall, Vice President/Operations.
(5) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

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.

This standard requires that the agency not hire or promote to a position requiring contact with residents, anyone who has engaged in specified types of prohibited conduct. The specific prohibited acts are outlined in (a), (1)-(3) of Standard 115.217. The hiring process for facility employees includes an initial interview at the facility level. There is no provision within the PREA policy requiring an inquiry into an applicant's prior history of being engaged in sexual abuse within a confinement facility; having been convicted of engaging or attempting to engage in sexual activity in the community by force, threat of force, or lack of consent; or having been civilly or administratively adjudicated of engaging in or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent. During the course of interviews and discussions with administrative staff, it was determined that the selection process for employees to include volunteers and contractors does take into account past employee conduct and criminal history, but not in the specific form that is required by the standard. The Keeton Corrections Inc. employment application does make an inquiry which captures any prior criminal convictions or civil adjudications but it does not address administrative adjudications as required by the standard. The applicant questionnaire contains a section regarding a discussion of ethical issues generally but it does not address the applicants history of sexual abuse. Under the current employee evaluation system, employees do not submit written self-evaluations so the component of the standard requiring a statement as to past misconduct within a written self-evaluation does not apply to facility staff. The Facility Director indicated that it would be the practice to share information regarding substantiated allegations of sexual abuse or sexual harassment against a former employee upon receiving a request from a current prospective institutional employer. This is not provided for in the PREA policy or a related personnel policy. Pursuant to the contract with the Federal Bureau of Prisons, each applicant recommended for hire must successfully complete a background investigation which includes a criminal history records check by the National Criminal Information Center/National Law Enforcement Telecommunication System (NCIC/NLETS). Three random personnel files were reviewed to ensure employees who may have contact with residents have completed the required federal background check. Each file contained the appropriate documentation. Employees who are charged criminally while employed by the agency are required to report this to the facility. This system negates the necessity of conducting criminal history records checks of current employees every five years.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA.
(2) Mobile-Statement of Work, pp. 14-15 (background check required for employees working with BOP offenders).
(3) Keeton Corrections Employee Orientation Packet-Standards of Conduct, Item 17 (requirement of current employees to report new arrests or convictions or suspension or revocation of drivers license).
(4) Auditor Review-BOP Form-REQUEST FOR CONTRACT STAFF BACKGROUND INVESTIGATION.
(5) Auditor Review-Sample Background Investigation Clearance Letter.
(6) Auditor Review-Six Randomly Selected Employee Personnel Files (6 of 6 contained documentation of federal background check).
(7) Auditor Review-Sample Employee Interview Form.
(8) Auditor Notes- Interview with Lucy May, Facility Director.
(9) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1.) Incorporate language into the PREA policy or an applicable personnel policy that requires inquiry into an applicant's history of engaging in sexual abuse within a confinement facility; and conviction, civil adjudication, or administrative adjudication of engaging in or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent.
(2.) Add specific questions to the Keeton Corrections application for employment and the applicant interview form inquiring into an applicant's history of engaging in sexual misconduct within a confinement facility and the applicants conviction, civil adjudication, or administrative adjudication of engaging in or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent.
(3.) Incorporate language into the PREA policy or an applicable personnel policy, that the agency will not hire, promote, or enlist the

services of a contractor who has a history of engaging in sexual abuse within a confinement facility or who was convicted, civilly adjudicated, or administratively adjudicated; of engaging in or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent.

(4.) Incorporate language into the PREA polcy or an applicable personnel policy, that material omissions or false statements concerning an applicants history of sexual abuse shall be grounds for termination.

(5.) Incorporate language into the PREA policy or an applicable personnel policy, that the facility will share information regarding substantiated allegations against former employees upon inquiry from a current prospective institutional employer.

(6.) Conduct and document staff training on the revised policies.

(1) Plan of Corrective Action/Deliverables:

(A) Assigned Staff-Byron Jasis and the Facility Director.

(B) Task- Incorporate language into the PREA policy or an applicable personnel policy that requires inquiry into an applicant's history of engaging in sexual abuse within a confinement facility; and conviction, civil adjudication, or administrative adjudication of engaging or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent.

(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance. The revised policy includes language requiring inquiry into an applicant's history of engaging in sexual abuse within a confinement facility; and conviction, civil adjudication, or administrative adjudication of engaging or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance (revised) at pp.2-3.

(2) Plan of Corrective Action/Deliverables:

(A) Assigned Staff-Byron Jasis and the Facility Director.

(B) Task- Add specific questions to the Keeton Corrections application for employment that requires inquiry into an applicant's history of engaging in sexual abuse within a confinement facility; and conviction, civil adjudication, or administrative adjudication of engaging or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent.

(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On August 26, 2016 the auditor reviewed the Keeton Corrections application for employment. Upon review it was determined that language had been added to the Keeton Corrections application for employment requiring inquiry into an applicant's history of engaging in sexual abuse within a confinement facility; and conviction, civil adjudication, or administrative adjudication of engaging or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent. The facility is now in compliance with this componenet of the standard.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Application for Employment (revised) at page 1.

(3) Plan of Corrective Action/Deliverables:

(A) Assigned Staff-Byron Jasis and the Facility Director.

(B) Task- Incorporate language into the PREA policy or an applicable personnel policy, that the agency will not hire, promote, or enlist the services of a contractor who has a history of engaging in sexual abuse within a confinement facility or who was convicted, civilly adjudicated, or administratively adjudicated; of engaging in or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent.

(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance. The revised policy included language that the agency will not hire, promote, or enlist the services of a contractor who has a history of engaging in sexual abuse within a confinement facility or who was convicted, civilly adjudicated, or administratively adjudicated; of engaging in or attempting to engage in sexual activity within the community by force, threat of force, or lack of consent. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance (revised) at page 2.

(4) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Incorporate language into the PREA polcy or an applicable personnel policy, that material omissions or false statements concerning an applicants history of sexual abuse shall be grounds for termination.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance. Language has been added to the policy that material omissions or false statements concerning an applicants history of sexual abuse shall be grounds for termination. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance (revised) at page 3.

(5) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Incorporate language into the PREA policy or an applicable personnel policy, that the facility will share information regarding substantiated allegations against former employees upon inquiry from a current prospective institutional employer.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviwed Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance. Upon review it was determined that the revised policy cantained language that the facility will share information regarding substantiated allegations against former employees upon inquiry from a current prospective institutional employer. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance (revised) at p. 3.

(6) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Conduct and document staff training on the revised policies.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed memorandum from Lucy May dated December 1, 2016. The memorandum documented that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard requires when designing or acquiring a new facility or when contemplating a substantial expansion or modification to an existing facilty, the effect of the proposed design, acquisition, expansion, or modification on the agency's ability to protect residents from sexual abuse is considered. Additionally, when monitoring technology is installed or upgraded, the use of technology to enhance the agency's ability to protect residents from sexual abuse is considered. During the course of the interview with Karen Hall, Vice President of Operations, it was confirmed that the above-listed factors were considered when new facilities were designed or acquired or when substantial modifications were made to existing facilities.

Policy, Matrials, Interviews, and Other Evidence Reviewed:
(1) Physical Plant Schematic Diagram.
(2) Auditor Observation-Camera Placement.
(3) Auditor Notes-Interview with Karen Hall, Vice President/Operations.
(4) Auditor Notes-Interview with Lucy May, Facility 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)

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.

This standard requires that facilities conducting in-house investigations follow a uniform evidence protocol which conforms with specific guidelines outlined in sections (a)-(b) of standard 115.221. Additionally, the facility shall provide access to forensic medical examinations and related follow-up services such as victim advocacy. The type of services that must be provided are listed in sections (c)-(d) of the standard. Based on interviews with administrative staff it was determined that the facility does have a number of processes in place that are

designed to comply with the evidence protocol and provide for forensic examinations and victim advocacy services in the event an incident requiring these services should occur. The facility refers allegations of sexual abuse to the Baldwin County Sheriff's Office for investigation. There was no formal Memorandum of Understanding (MOU) on file at the facility outlining the investigative services that would be provided by the Baldwin County Sheriff's Office. The facility staff is responsible for the initial response which includes separation of the victim and perpetrator, ensuring medical treatment is rendered as needed, securing the scene, and preserving physical evidence. The initial steps taken at the facility level are in conformity with the general standrds for ensuring the safety of the affected residents and preserving potential evidence. The pre-audit questionnaire indicate sexual assault forensic medical examinations will be provided by USA Children and Women's Hospital in Mobile, Alabama but there is no Memorandum of Understanding with the hospital. The facility has a formal Memorandum of Understanding (MOU) with the Lighthouse Counseling Center (LCC) to provide a variety of services to residents of the facility. Services include a confidential 24 hour hotline which residents may use to report incidents of sexual abuse (includes 3rd party reporting). The MOU does not specifically state whether or not LCC will assist in providing access to a Sexual Assault Forensic Exam (SAFE) program location but the coordination of these services is listed one LCC's web page. The facility does not have a formal MOU with the Baldwin County Sheriff's Office that specifies the scope of investigative services that the office will provide to the facility. The facility should seek to obtain an MOU with the Marion County Sheriff's Office specifying the scope of investigative services that the office will provide to the facility and documenting that the office wil adhere to the requirements of the protocol for sexual assault forensic medical examinations. The pre-audit questionnaire indicated that sexual assault forensic medical examinations would be provided by Monroe Regional Hospital. The facility should obtain a Memorandum of Understanding (MOU) with the hospital which specifies the type of medical services that will be provided to sexual abuse victims. The MOU should specifically include language indicating sexual assault forensic medical examinations are included within the range of medical services provided as well as language indicating the h ospital will adhere to the DOJ protocol for sexual assault forensic medical examinations. It is noted that the agency/facility cannot control the investigative protocols utilized by other allied agencies. Based on this, if certification statements regarding the forensic examination protocols cannot be documented within the MOU with each allied agency, the facility should document that the allied agencies have been made aware of the protocols. This can be accomplished by regular communications channels such as by letter or email. The facility indicated there were no incidents during the 12 months preceding the audit that required forensic examinations or the use of follow-up services such as victim advocate services. During interviews and discussions with administrative staff, it was determined that the facility would comply with the requiements of the standard if an incident requiring the utilization of these services actually occurred.

Policy, Materials, Interviews, and other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Ass ault and PREA, pp. 8-9.
(2) MOU between Keeton Corrections Inc. and LCC.
(3) Pre-audit Questionnaire.
(4) Auditor Notes-Interview with Lucy May, Facility Director.
(5) Auditor Notes-Interview with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Obtain signed MOU with Baldwin County Sheriff's Office outlining the investigative services that will be provided to the facility.
(2) Amend the agreement with the Lighthouse Counseling Center (LCC) to clarify whther or not the center will provide access to a SAFE program (if so, add language that the center will adhere to the DOJ National Protocol for Sexual Assault Forensic Medical Examinations).
(3) Obtain documentation from the Baldwin County Sheriff's Office outlining the investigative services the office will provide to the facility including a statement the office will abide by the DOJ National Protocol for Sexual Assault Forensic Medical Examinations.
(4) Obtain a Memorandum of Understanding (MOU) with the USA Children and Women's Hospital explaining the scope of medical services the hospital will provide for sexual abuse victims.
(5) Ensure the MOU with USA Children and Women's Hospital contains language that the hospital will adhere to the DOJ National Protocol for Sexual Assault Forensic Medical Examinations.
(6) In the absence of an agreement that the allied agencies will adhere to the protocol for sexual assault forensic medical e xaminations the facility should document that these allied agencies have been made aware of the protocol.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Obtain signed MOU with the Baldwin County Sheriff's Department outlining the investigative services that will be provided to the facility.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added indicating that sexual abuse and sexual harassment investigations shall initially be conducted at the facility level by trained Keeton Corrections, Inc. staff. Conduct rising to the level of criminal behavior shall be referred to outside law enforcement agencies. On December 19, 2016 the auditor reviewed an email from Jerica Poellnitz confirming the facility continues to operate under an

informal agreement with the Baldwin County Sheriff's Office under which the sheriff's office will provide law enforcement services to the facility. The facility attempted to enter into a formal Memorandum of Understanding (MOU) between the facility and the sheriff's office but the sheriff's office declined to enter into a formal agreement. The Baldwin County Sheriff's office mission statement was presented which confirmed that the sheriff's office would provide law enforcement services on a county-wide basis. Although a formal agreement with the sheriff's office is desirable, it is not essential in demonstrating compliance with the standard. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 10.
(2) Baldwin County Sheriff's Office Mission Statement.
(3) Email from Jerica Poellintz dated December 19, 2016 documenting the attempt to enter into a MOU with the Baldwin County Sheriff's Office.

(2) Plan of Corrective Action/Deliverables:

(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Amend the agreement with the Lighthouse Counseling Center (LCC) to clarify whther or not the center will provide access to a SAFE program (if so, add language that the center will adhere to the DOJ National Protocol for Sexual Assault Forensic Medical Examinations).
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the audit:

On December 15, 2016 the auditor reviewed the most recent Memorandum of Understanding (MOU) between the facility and Lighthouse Counseling Center (LCC) dated June 20, 2016. The MOU references a variety of services for victims of sexual abuse which are detailed on the LCC's web site. The web site confirms that sexual assault victims be provided access to community-based SAFE programs if needed. On December 19, 2016 Byron Jasis confirmed via email that LCC would coordinate with the USA Chidren and Women's Hospital as the community-based provider that would perform the SAFE examinations if warranted. On December 19, 2016 the auditor reviewed an email from Jerica Poellnitz dated December 19, 2016 which documented the USA Children and Women's Hospital had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) MOU between the facility and Lighthouse Counseling Center (LCC) dated June 20, 2016.
(2) Email from Byron Jasis dated December 19, 2016 confirming the Children and Women's Hospital would conduct SAFE examinations when warranted.
(3) Lighthouse Counseling Services Web Site.
(4) Email from Jerica Poellintz dated December 19, 2016 documenting that the Children and Women's Hospital had been made aware of the DOJ National Protocal for Sexual Assault Forensic Medical Examinations.

(3) Plan of Corrective Action/Deliverables:

(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Obtain documentation from the Baldwin County Sheriff's Department outlining the investigative services the department will provide to the facility including a statement the office will abide by the DOJ National Protocol for Sexual Assault Forensic Medical Examinations.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. The policy has been revised to clarify the duties of in-house investigators employed by the agency and external investigators employed by outside law enforcement agencies. Administrative investigations involving conduct not rising to the level of criminal behavior shall be conducted by agency staff trained to conduct sexual misconduct investigations. Investigations involving conduct rising to the level of criminal behavior shall be conducted by outside law enforcement agencies. On December 19, 2016 the auditor reviewed an email from Jerica Poellintz confirming that the facilty continues to operate under an informal agreement with the Baldwin County sheriff's Office under which the sheriff's office will provide law enforcement services to the facility. The policy revisions clarifying the role of outside law enforcement agencies when considred in conjunction with the informal agreement with the sheriff's office are sufficient to demonstrate compliance with the requirements of the standard. On December 19, 2016 the auditor reviewed an email from Jerica Poellintz dated December 19, 2016 documenting that the Baldwin County Sheriff's Office had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations.

The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 10. Email from Jerica Poellintz confirming that the facility continues to operate under an informal agreement with the Baldwin County Sheriff's Office.
(2) Email from Jerica Poellintz dated December 19, 2016 documenting that the Baldwin County Sheriff's Office had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations.

(4) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Obtain a Memorandum of Understanding (MOU) with the USA Children and Women's Hospital explaining the scope of medical services the hospital will provide for sexual abuse victims.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 19, 2016 the auditor reviewed an email from Byron Jasis dated December 19, 2016 in which he confirmed the USA Children and Women's Hospital will provide emergency medical treatment (including sexual assault forensic medical examinations) for residents of the facility. These services are provided pursuant to an informal agreement with the hospital in lieu of a formal Memorandum of Understanding (MOU). Although a MOU outlining the scope of services to be provided is desirable, it is not essential to demonstrate compliance with the standard. The facility is now in compliance with this item of corrective action and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Email from Byron Jasis dated December 19, 2016 confirming the USA Children and Women's Hospital will provide emergency medical services to the facility.

(5)Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Ensure the MOU with USA Children and Women's Hospital contains language that the hospital will adhere to the DOJ National Protocol for Sexual
Assault Forensic Medical Examinations.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 19, 2016 the auditor reviewed an email from Byron Jasis dated December 19, 2016. The email confirmed that USA Children and Women's Hospital would be utilized to provide emergency medical care (including sexual assault forensic medical examinations) for residents of the facility based on an informal agreement between the facility and the hospital. Although it is desirable to maintain a formal agreement between the facility and the hospital it is not essential in determining that the facility meets the requirements of the standard. On December 19, 2016 the auditor reviewed an email from Jerica Poellintz documenting that the USA Children and Women's Hospital had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Email from Byron Jasis dated December 19, 2016 documenting the USA Children and Women's Hospital would provide emergency medical treatment to the facility.
(2) Email from Jerica Poellintz dated December 19, 2016 documenting that the USA Children and Women's Hospital had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations.

(6)Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- In the absence of an agreement that the allied agencies will adhere to the protocol for sexual assault forensic medical examinations

the facility should document that these allied agencies have been made aware of the protocol.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 19, 2016 the auditor reviewed an email from Jerica Poellnitz dated December 19, 2016 documenting that the Baldwin County Sheriff's Department had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations. Additionally, on December 19, 2016 the auditor reviewed an email from Jerica Poellnitz dated December 1, 2016 documenting that the Lighthouse Counseling Center (LCC) had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations. The facility is now in compliance with this corrective action item and the standard in general. On December 19, 2016 the auditor reviewed an email from Jerica Poellintz documenting that the USA Children and Women's Hospital had been made aware of the DOJ National protocol for Sexual assault Forensic Medical Examinations. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Email from Jerica Poellintz dated December 19, 2016 documenting that the Baldwin County Sheriff's Department had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations.
(2) Email from Jerica Poellintz dated December 1, 2016 documenting that Lighthouse Counseling Center (LCC) had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations.
(3) Email from Jerical Poellintz dated December 19, 2016 documenting that the USA Children and Women's hospital had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical examinations.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard requires that an administrative or criminal investigation is conducted for all allegations of sexual abuse and sexual harassment. The facility reported that there were no allegations of sexual abuse or sexual harassment that occurred during the 12 months preceding the audit. Accordingly, there were no administrative or criminal investigations which occurred. After interviews and discussions with administrative staff, it was determined that the facility has a mechanism in place to ensure all incidents of sexual abuse or sexual harassment would be investigated in the event an actual incident occurred. The facility will refer allegations of sexual abuse to the Marion County Sheriff's Office for investigation. There is no memorandum of understanding (MOU) on file at the facility which outlines the scope of investigative services that will be provided by the Baldwin County Sheriff's office. To clarify the role of each agency, a MOU outlining the scope of services provided by the sheriff's office should be obtained. In most cases, law enforcement agencies will only investgate incidents involving criminal conduct. Incidents that don't rise to the level of criminal conduct may be investigated administratively at the facility level. Cases such as this are normally handled by the Facility Director. Pusuant to the contract with the Federal Bureau of Prisons,

allegations of staff misconduct must be referred to a designated representative within the Federal Bureau of Prisons who shall determine if the investigation will be done at the facility level or referred to a BOP investigator or an allied federal law enforcement agency. The facility should obtain documentation that investigations into allegations of sexual abuse conducted by the BOP or other federal law enforcement agencies will conform to the DOJ protocol for sexual assault forensic medical examinations. If documentation that the agencies will conform to the protocol cannot be obtained, the facility should document that it has made the BOP or other federal law enforcement agencies aware of protocol.

Policy, Materials, Interviews, or Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp. 8-10.
(2) Mobile- Statement of Work, p.18 (contractor prohibited from conducting investigations into alleged staff misconduct without the prior approval of the BOP).
(3) Auditor Notes-Interview with Lucy May, Facility Director.
(4) Auditor Notes, Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Add language to the PREA policy which clearly establishes to what extent the facility or agency will investigate incidents of sexual abuse and sexual harassment internally, without a referral to outside law enforcement.
(2) Add language to the PREA policy which clearly establishes the circumstances that would trigger an investigation by a law enforcement agency.
(3) Obtain a signed MOU with the Baldwin County Sheriff's Office which clearly defines the investigative services that will be provided to the facility.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Add language to the PREA policy which clearly establishes to what extent the facility or agency will investigate incidents of sexual abuse and sexual harassment internally, without a referral to outside law enforcement.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added indicating that sexual abuse and sexual harassment investigations shall initially be conducted at the facility level by trained Keeton Corrections, Inc. staff. Conduct rising to the level of criminal behavior shall be referred to outside law enforcement agencies. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1(formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 10.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Add language to the PREA policy which clearly establishes the circumstances that would trigger an investigation by a law enforcement agency.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language has been added to the policy that indicating that sexual misconduct involvolving potentially criminal behavior would be referred to the appropriate law enfocrcement agency for investigation. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 10.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Obtain a signed MOU with the Baldwin County Sheriff's Office which clearly defines the investigative services that will be provided to the facility.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added indicating that sexual abuse and sexual harassment investigations shall initially be conducted at the facility level by trained Keeton Corrections, Inc. staff. Conduct rising to the level of criminal behavior shall be referred to outside law enforcement agencies. On December 19, 2016 the auditor reviewed an email from Jerica Poellnitz confirming the facility continues to operate under an informal agreement with the Baldwin County Sheriff's Office under which the sheriff's office will provide law enforcement services to the facility. The facility attempted to enter into a formal Memorandum of Understanding (MOU) between the facility and the sheriff's office but the sheriff's office declined to enter into a formal agreement. The Baldwin County Sheriff's office mission statement was presented which confirmed that the sheriff's office would provide law enforcement services on a county-wide basis. Although a formal agreement with the sheriff's office is desirable it is not essential in demonstrating compliance with the standard. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 10.
(2) Baldwin County Sheriff's Office Mission Statement
(3) Email from Jerica Poellintz dated December 19, 2016 documenting the attempt to enter into a MOU with the Baldwin County Sheriff's Office.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard outlines the manadated PREA related topics that staff who may have contact with residents are required to complete. The specific topics are listed in (a), (1)-(10) of Standard 115.231. The training shall be tailored to the gender of the residents housed at the facility. The initial training shall have been completed within one year of the effective date of the PREA standards and refresher training must be provided every two years. Based on interviews and discussions with administrative staff it was determined facility staff who may have contact with residents are required to complete training in the designated PREA related topics. Facility staff receive training in the zero tolerance policy; employee responsibilities under agency policy in the prevention, detection, reporting, and response to sexual abuse and sexual harassment; the right of residents to be free from sexual abuse and sexual harassment; the right of residents and staff to be free from retaliation for reporting sexual abuse and sexual harassment; the dynamics of sexual abuse and sexual harassment within a confinement facility; the common reactions of sexual abuse and sexual harassment victims; how to detect and respond to signs of threatened and actual sexual abuse; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Since the facility houses both male and female residents, the training is not

tailored to one specific gender. Employees sign an acknowledgement indicating they understand the training they have received. The training is documented in the employee personnel file. A spot check of six randomly selected employee training records indicated each staff member had recived the required training and had signed an acknowledgement indicating they understood the training. The employees were randomly selected by the auditor from the staff roster. The auditor utilized a random selection method utilizing the first letter of the staff member's last name to select the files to be reviewed. Additionally, staff selected for random staff interviews confirmed that they had been trained in the required topics. The auditor reviewed the training curriculum to ensure each of the prescribed topics were covered.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp.15-16.
(2) Mobile- Statement of Work, p. 13, (staff must complete training prior to working with BOP residents), p. 14, (staff must complete annual refresher training).
(3) Auditor Review-Lesson Plan (staff PREA training).
(4) Auditor Review- six randomly selected personnel files (containing staff PREA training records-6 of 6 contained the appropriate documentation).
(5) Interviews-random staff (8 of 8 facility staff interviewed confirmed they had received the required training).

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard requires that all volunteers and contractors who have contact with residents receive training in their responsibilities under the agency sexual abuse and sexual harassment prevention, detection, and response policies. After interviews and discussion with administrative staff, it was determined that currently the facility does not utilize contractors or unsupervised volunteers to provide services to residents of the facility. Supervised volunteers are utilized to deliver religious programming and financial planning training to resdents of the facility. It is strongly recommended that the supervised volunteers complete orientation and training in PREA related topics since they have direct contact with residents. The facility has a policy in place which would require that if contractors or unsupervised volunteers were used they woud be required to complete training in the zero tolerance polcy and their responsibilities under the agency policies in the prevention, detection, and response to sexual abuse and harassment. It was confirmed during interviews and discussions with administrative staff that the requirements of the standard would be met in the event the facility utilized the services of contractors or unsupervised volunteers in the future.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p.4.
(2) Keeton Corrections Policy and Procedure 2.9, Recuitment, Training, Volunteer Coordination, and Severance, p. 22.
(3) Mobile-Statement of Work, p. 22 (facility required to list volunteers on the staff roster).
(4) Auditor Notes-Interview with Lucy May, Facility Director.
(5) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard requires that during intake, residents receive information regarding the agency PREA policies. The specific information to be provided is outlined in Section (a) of Standard 115.233. The agency must provide refresher information whenever a resident is transferred to a different facility. The information to be provided must be accessible to all residents including those with special communications needs. The facilty shall document that each resident has participated in these education sessions. Additionally, the facility must ensure that the key information is readily accessible on a continuing basis. After interviews and discussions with administrative staff and a review of the applicable policies and practices, it was determined that the facility provides PREA realted information to residents in accordance with the requirements of the standard. During the intake process, residents receive information explaining the zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse or sexual harassment, their rights to be free from retaliation for reporting incidents or suspicions of sexual abuse or sexual harassment, and agency policies and procedures for responding to such incidents. The resident training is delivered by the staff member assigned as the Social Services Coordinator. Materials include handout pamphlets which are printed in both English and Spanish. The pamphlets address what constutes sexual abuse and sexual harassment, the right of the resident to be free from sexual abuse and sexual harassment, and how to report sexual abuse and sexual harassment. Residents sign an acknowledgement that they have received and understand the PREA materials. Three resident files were randomly reviewed to ensure they included documentation that the resident had received the PREA information during the intake process. The residents were selected from the census roster. Each file contained the appropriate document ation. Additionally, 8 of 8 residents selected for random interviews confirmed that they received the required PREA related information during intake. Information reinforcing the materials contained in the pamphlets are contained in posters which are displayed in various parts of the facility including the dormitories and multi-purpose room. The facility has a policy in place under which they can provide services for residents who are hearing impaired, need the services of an interpretor, or have other special communications needs. Administrative staff confirmed that the facility would take appropriate measures to meet the specific communications needs of the resident. Specific examples mentioned included enlisting the services of an interpretor or purchasing special equipment such as hearing amplification aides.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp. 5-6.
(2) Mobile- Statement of Work, pp. 8-9, (contractor shall provide translation services as needed based on the composition of the population).
(3) Auditor Review-(six randomly selected resident files-each contained documentation the resident had received the PREA information).
(4) Handout-PREA Informational Pamphlet (English and Spanish).
(5) Auditor Observation-PREA Information Posters.
(6) Auditor Notes-Interview with Cora Crenshaw, Social Services Coordinator (staff member responsible for delivery of PREA information during intake).
(7) Resident Random Interviews (8 of 8 residents interviewed confirmed they had received the PREA information during intake).

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.

This standard requires that agency/facility staff who conduct investigations receive specialized training. Specific topics to be addressed in the training are listed in Sections (a)-(b) of Standard 115.234. Interviews with administrative staff indicated that some level of administrative investigation into allegations of sexual abuse or sexual harassment will be conducted at the facility level. The PREA policy has a provision that any administrative investigations resulting in in substantiated cases of sexual abuse shall be reviewed to determine whether

staff actions or failure to act contributed to the abuse. The facility also has an informal agreement with the Baldwin County Sheriff's Office that they will conduct investigations into allegations of sexual abuse. The policy does not make a clear distinction as to what type of issues will be investigated at the facility level and what type of issues will be investigated by the Marion County Sheriff's Office and there is no formal Memorandum of Understanding (MOU) which specifies the extent of the investigative services that will be provided by the Baldwin County Sheriff's Office. In most jurisdicions, the determining factor as to whether or not the case will be investigated by law enforcement authorities is whether or not the alleged behavior rises to the level of criminal conduct, based on the laws of the jurisdiction where the facility is located. Making this determination requires a degree of coordination between the facility and the involved law enforcement agency and at least some degree of preliminary investigation at the facility level. Although the facility reports there have been no allegations of sexual abuse during the 12 months preceding the audit, if a sexual abuse allegation was made, a preliminary investigation of this type would be conducted by the Facility Director who serves as the PREA Compliance Manager at the facility level. Interviews and discussions with administrative staff indicated that at the time of the audit, neither the Director or anyone else at the facility had received specialized investigative training. Accordingly, the Director should receive specialized investigative training to meet the requirements of the standard. The training should include tecniques for interviewing sexual abuse victims, sexual abuse evidence collection in confinement settings, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantaiate a case for administrative action or a referral for prosecution.

Policies, Materials, Interviews and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 10.
(2) Organizational Chart (designating the facility director as the facility PREA Compliance Manager).
(3) Auditor Notes-Interview with Lucy May, Facility Director.
(4) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Revise the PREA policy to clearly define the duities of the institutional investigator as distinguished fronm the investigative functions that will be performed by the Baldwin County Sheriff's Office.
(2) Obtain a signed MOU with the Baldwin County Sheriff's Office which includes the specific investigative services that will be provided to the facility.
(3) Revise the PREA policy at page 9 to replace the reference to the "Florida Sate Police" with "appropriate law enforcement agency" (this is an agency level policy, the specific law enforcement agency will vary based on the location of the facility).
(4) Conduct staff training on the revised policies.
(5) Ensure the Facility Director completes specialized training for sexual abuse investigators amd document completion of the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy to clearly define the duities of the institutional investigator as distinguished fronm the investigative functions that will be performed by the Birmingham Police Department.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. The policy has been revised to clarify the duties of in-house investigators employed by the agency and external investigators employed by outside law enforcement agencies. Administrative investigations involving conduct not rising to the level of criminal behavior shall be conducted by agency staff trained to conduct sexual misconduct investigations. Investigations involving conduct rising to the level of criminal behavior shall be conducted by outside law enforcement agencies. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 10.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Obtain a signed MOU with the Baldwin County Sheriff's Office which includes the specific investigative services that will be provided to the facility.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added indicating that sexual abuse and sexual harassment investigations shall initially be conducted at the facility

level by trained Keeton Corrections, Inc. staff. Conduct rising to the level of criminal behavior shall be referred to outside law enforcement agencies. On December 19, 2016 the auditor reviewed an email from Jerica Poellnitz confirming the facility continues to operate under an informal agreement with the Baldwin County Sheriff's Office under which the sheriff's office will provide law enforcement services to the facility. The facility attempted to enter into a formal Memorandum of Understanding (MOU) between the facility and the sheriff's office but the sheriff's office declined to enter into a formal agreement. The Baldwin County Sheriff's office mission statement was presented which confirmed that the sheriff's office would provide law enforcement services on a county-wide basis. Although a formal agreement with the sheriff's office is desirable, it is not essential in demonstrating compliance with the standard. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 10.
(2) Baldwin County Sheriff's Office Mission Statement.
(3) Email from Jerica Poellintz dated December 19, 2016 documenting the attempt to enter into a MOU with the Baldwin County Sheriff's Office.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director
(B) Task- Revise the PREA policy at page 9 to replace the reference to the "Florida Sate Police" with "appropriate law enforcement agency." (this is an agency level policy, the specific law enforcement agency will vary based on the location of the facility).
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language had been added to the policy substituting "appropriate law enforcement agency" for "Florida State Police." The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 9.

(4) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Conduct staff training on the revised policies.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016. The memorandum documented that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

(5) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Ensure the Facility Director completes specialized training for sexual abuse investigators amd document completion of the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and As sault and PREA. The policy includes language that incidents of sexual abuse and sexual harassment shall be initially investigated by agency staff who have received specialized training in conducting investigations into incidents of sexual misconduct. In lieu of having each facility director complete specialized investigator training, the agency has designated Byron Jasis as the agency-level staff member who will conduct in-house investigations into allegations of sexual misconduct. This system meets the requirements of the stan dard. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 10.
(2) Memo from Karen Hall dated November 2, 2016 desiganating Byron Jasis as the agency-level PREA investigator.
(3) Byron Jasis Training Record dated March 21, 2014 (showing completion of 16 hours of PREA Investigator Training).

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.

This standard is not applicable to the Mobile Community Services Center. After discussion with administrative staff it was determined that the facility does not employ medical or mental health practitioners on a full-time or part-time basis. This was also confirmed by a review of the staff roster which lists each employee by name and job title. During the course of discussions with administrative staff, it was confirmed that in the event the facility employs medical or mental health practitioners at a later date, the facility will comply with the requirements of the standard.

Policy, Materials, Interviews and Other Evidence Reviewed:
(1) Auditor Review-Staff Roster (no medical/mental heath practitioners on staff).
(2) Auditor Notes- Interview with Lucy May, Facility Director.

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.

This standard requires that residents be screened for risk of victimization or abusiveness within 72 hours of arrival at the facility. The risk screening must be conducted by means of a screening instrument that considers specific factors outlined in (d), (1)-(9) of Standard 115.241. After the initial screening, residents must be reassessed when warranted due to a referral, request, incident, or receipt of additional information. Additionally, all residents must be reassessed within a specified time frame not to exceed 30 days after arrival at the facility. After interviews and discussion with administrative staff and a review of the applicable policies and practices, it was determined that residents are initially screened in accordance with the requirements of the standard but there is no affirmative reassessment within 30 days after arrival. Incoming residents are screened for risk of victimization or sexual abusiveness toward other residents within 24 hours of arrival at the facility. The screening instrument is completed by the Social Services Coordinator. During the screening, residents are given the option to self-report if they consider themselves to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming. Additionally, the screening instrument utilized to assess the risk for victimization considers whether the resident has a mental, physical, or developmental disability; the age of the resident; the physical build of the resident; whether the resident has been previously incarcerated; whether the resident's criminal history is exclusively nonviolent; whether the resident has prior convictions for sex offenses against an adult or child; whether the resident is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the resident has previously experienced sexual victimization; and the resident's own perception of vulnerability. The screening instrument utilized to assess the resident's risk of sexual abusiveness toward other residents considers prior acts of sexual abuse, prior convictions for violent offenses, and the resident's history of prior institutional violence, as known to the agency. Six resident files were randomly selected to ensure there were records of completion of the risk screening intake form within each file. The residents were selected from the census roster. Each resident file contained the required documentation. Although the screening form includes all of the mandated risk factors listed at (d), (1)-(9) within standard 115.241, these factors are not included within the language of the PREA policy. This language needs to be included within the policy to ensure any revisions to the screening instrument do not eliminate a required componenet of the standard. During the course of interviews and discussion with administrative staff, it was confirmed that a resident's risk for victimization or abusiveness shall be reassessed whenever warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of victimization or abusiveness. It was further determined that currently, there is no affirmative reassessment of the risk for victimization or abusiveness within 30 days of the resident's arrival at the facility as is required by the standard. Language needs to be added to the PREA policy requiring an affirmative reassessment of the risk within 30 days of arrival. Residents are not subject to disciplinary sanctions for refusing to answer or not fully disclosing the information sought in response to the questions contained in the screening instrument. The information recorded on the screening form is considered confidential and is only disclosed to staff with a bona fide "need to know."

Policy, Materials, Interviews and Other Evidence reviewed:

(1) Keeton Corrections Policy and Proceedure 22, Sexual Abuse and Assault and PREA, pp. 6-7.
(2) National PREA Resources Center-Interpretation of Standard 115.241 (reference FAQ dated June 20, 2014-an affirmative reassessment is required within 30 days of the resident's arrival at the facility).
(3) Auditor Review- Intake Risk of Victimization/Abusiveness Screening Form (all required items included on screening form).
(4) Auditor Obervation (six of six randomly selected files contained the appropriate intake risk screening documents completed at intake).
(5) Auditor Notes-Interview with Cora Crenshaw, Social Services Coordinator (staff member who complests the risk screening form).
(6) Auditor Notes-Discussion with with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Revise the PREA policy to include language outlining the mandatory components of the intake risk screening document.
(2) Revise the PREA policy to add language ensuring an affirmative reassessment within a specified time not to exceed 30 days from the date of arrival.
(3) Train staff on the polcy revisions and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy to include language outling the mandatory components of the intake risk screening document.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 7.3, Inatke. Language had been added to the policy outlining the mandatory componenets of the intake risk screening document outlined in (d), (1)-(9) of Standard 115.241. The facilty is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 7.3, Intake (revised) at page 3.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy to include an affirmative reassessment of risk within 30 days of the resdient's arrival.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 7.3, Intake. Language has been added to the p olicy confirming that the facility has an affirmative duty to conduct a reassessment of risk for victimization or abuseiveness within 30 days of arrival. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 7.3, Intake (revised) at page 3.
(2) Email from Byron Jasis dated November 8, 2016 confirming the practice of conducting the reassessments within 30 days of arriv al.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Train staff on the polcy revisions and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policies. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Memorandum from Lucy May dated December 1, 2016 documenting facility staff had been trained in the revised policies.

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.

This standard requires that the agency use information from the risk screening to inform housing, bed, work, education, and progra m assignments. The standard also has specific requirements regarding the placement of transgender or intersex residents which are listed in sections (a)-(e) of Standard 115.242. Additional requirements regarding the placement of residents who are lesbian, gay, bisexual,

transgender or intersex are listed in section (f) of the standard. The PREA policy states in general terms that the information from the screening will be utilized to inform decisions regarding housing, bed, work, education, and program assignments. The PREA policy does not address how screening information shall be utilized in determining appropriate housing for lesbian, gay, bisexual, transgender or intersex residents other than to reference the applicable sections of Standard 115.242. The facility reports that they have not received any transgender or intersex residents within the 12 months preceding the audit. Addionally, there have been no cases in which residents have self-reported as being transgender within the preceding 12 months. Based on interviews and discussions with administrative staff members, there is no specific policy as to how placement decisions would be made as to residents identifying or perceived as gay, lesbian, bisexual, transgender, intersex, or gender nonconformimg. When the hypothetical question was asked regarding how a resident presenting as transgender woud be housed, there was no definative answer other than the agency corporate office and the federal customer (BOP) would have to be consulted. At a minimum, policy language should be added to the PREA policy that requires that decisions regarding the placement of transgender or intersex residents shoud be made on a case by case basis and that the determination cannot be based on one singular factor such as the presence or absence of male/female genitilia. The policy shoud also indicate that the affected resident 's own views regarding appropriate placement should be given serious consideration. Additionally, the policy should prohibit the utilization of a dedicated facility, housing unit, or living unit wing for placement of residents who are gay, lesbian , bisexual, transgende r, or intersex unless this is required pursuant to a consent decree, legal settlement, or legal judgement for the purpose of protecting these resid ents. If this applies, the facility should maintain a file copy of the applicable consent decree, legal se ttlement or legal judgment.

Policy, Materials, Interviews and Other Evidence Considered:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 7.
(2) National PREA Resource Center- Interpretation of Standard 115.242 (reference FAQ dated March 24, 2016-housing transgender or intersex residents based exclusively on external genital anatomy violates the standard).
(3) Auditor Notes-Interview with Terracina Davis, Quality Assurance Manager (agency level) and Agency PREA Cordinator.
(4) Auditor Notes-Interview with Lucy May, Facility Director.
(5) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Revise the PREA policy to reflect the requirements of the standard as to placement decisions regarding gay, lesbian, bisexual, transgender, and intersex residents.
(2) Train staff on the revised policy and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy to reflect the requirements of the standard as to placement decisions regarding gay, lesbian, bisexual, transgender, and intersex residents.

(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 7.3, Intake. Language has been added to the p olicy requiring that information derived from the risk screening instrument shall be used to make individualized decisions regardin g the placement of residents who identify or are perceived as gay, lesbian, bisexual, transgender, or intersex. The facilty is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 7.3, Intake (revised) at page 3.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Train staff in the revised policy and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016 documenting staff had been trained on the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting staff had been trained on the revised policy.

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.

This standard requires that the agency should provide multiple internal methods for residents to privately report sexual abuse, sexual harassment, and retaliation. The agency must also inform residents of at least one method of reporting sexual abuse or sexual harassment to a public or private entity outside the agency that is able to forward reports of sexual abuse to the agency with the identity of the reporting resident remaining anonymous if requested. After interviews and discussions with administrative staff, and a review of the applicable policies and practices, it was determined that the facility does provide multiple reporting options for residents who wish to report allegations of sexual abuse, sexual harassment, or retaliation for reporting these allegations. Residents may make reports to any staff member of the facility. There is no language within the PREA policy indicating staff will receive anonymous reports or reports from third parties. Information regarding third party and anonymous reports is not included in the PREA pamphlet but should be added. During the course of interviews and discussions with administrative staff it was determined that staff would accept anonymous and third party reports of sexual abuse, sexual harassment and retaliation. Additional reporting options for residents include reporting allegations of resident to resident sexual abuse to the Federal Bureau of Prisons National PREA Coordinator (contact information included in the PREA information pamphlet). Staff to resident sexual abuse may be reported to the Federal Bureau of Prisons Internal Affairs Division (contact information included in the PREA education pamphlet). During the course of the random resident interviews, 6 of 8 residents interviewed were aware they had the option to report allegations of sexual abuse to the Keeton Corrections Corporate Office but this was not addressed in the PREA policy or contained in the PREA information pamphlet. It is recommended that information as to how to make a report to the Keeton Corporate office be included in the PREA information pamphlet. Residents may also utilize the PREA hotline to report incidents of sexual abuse. The hotline is staffed by the Lighthouse Counseling Center, Inc. (LLC) an independent agency that serves as a 24 hour rape crisis center (anonymous and third party reports are accepted).

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp. 7-8.
(2) Audior Observation - PREA Hotline Poster (located in both dormitories and the multipurpose room).
(3) Auditor Review -PREA Information Pamphlet (distributed to residents during intake & contains information regarding how to make internal and external reports of sexual abuse and sexual harassment).
(4) Random Resident Interviews (6 of 8 residents were aware of the various reporting methods including the ability to make reports to the Keeton Corrections Inc. Corporate office).

Corrective Action Required:

(1) Add language to the PREA policy and the PREA pamphlet stating that staff will receive anonymous reports and reports from third parties.
(2) Trian staff on the policy revisions and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Add language to the PREA policy and the PREA pamphlet stating that staff will receive anonymous reports and reports from third parties.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and As sault and PREA and the PREA pamphlet distributed to residents of the facility. Upon review it was determined that language had be en added to both the PREA policy and the pamphlet that staff will receive anonymous reports and reports from third parties. The facility is no w in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 7.
(2) PREA Information Pamphlet (revised).

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Trian staff on the policy revisions and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016. The memorandum documented that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

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.

This standard requires that the agency provide an internal grievance mechanism which may be utilized by residents to report allega tions of sexual abuse. After interviews and discussions with administrative staff and a review of the applicable policies and prac tices, it was determined that the facility has an in-house grievance mechanism that is consistent with the requirements of the standard. The system currently in place permits residents to to submit grievances involving sexual abuse allegations directly to the Facilty Director. There is no time limititation on submitting a grievance concerning an allegation of sexual abuse. Upon receipt of a grieva nce alleging sexual abuse, the Facility Director shall render a response within 90 days of receipt of the grievance. The 90 day time limit may be extended for cause for a period of up to 70 days. Residents may file emergency grievances alleging sexual abuse with the Facility Director. Residents filing emergency grievances alleging sexual abuse will receive an initial response within 48 hours of submission and a final response within five calendar days of submission. The facility reports that there have been no incidents within the 12 months preceding the audit in which the grievance mechanism has been utilized to report allegations of sexual abuse. Accordingly, there were no applicable grievances for the auditor to review. Administrative staff confirmed that if an allegation of sexual abuse was reported by means of the grievanc e mechanism it would be handled in accordance with the requiements of this standard.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 15, Administrative Remedy, pp.124-125.
(2) Mobile -Statement of Work, p. 84, (contractor shall establish and maintain a written grievance procedure).
(3) Offender Handbook (specific section addressing grievance mechanism).
(4) Auditor Notes-Interview with Lucy May, Facility Director.
(5) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

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.

This standard requires the facility to provide residents with access to outside victim support services. After interviews and discussions with administrative staff and a review of the applicable policies and practices, it was determined that the facility will provide access to outside victim services. The facility reports that during the 12 months preceding the audit there have been no no allegations of sexual abuse. Accordingly, there have been no incidents in which a sexual assault victim has sought victim advocate services. Victim advocate services should be available to any abuse victim, even those who were victimized prior to incarceration. During the course of interviews and discussions with administrative staff, it was determined that the facility will provide access to victim support services if the need arises. The facility is currently operating under a Memorandum of Undertanding (MOU) with Lighthouse Counseling Center (LCC) to provide a variety of services to residents of the facility. Confidential victim support services to residents of the facility are included within the srvices provided. A review of the MOU with the LCC indicates that victims advocate services are included within the list of services that the LCC will provide to residents of the facility. The procedures for accessing the services provided by the LCC (including victim support services) are explained during the PREA orientation that is provided at intake. The contact number and mailing address for the LCC is included in the PREA pamphlet that is given to each resident during intake.

Policy, Materials, Interviews and Other Evidence reviewed:
(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 9.
(2) MOU between Keeton Corrections Inc. and LCC (includes victim support services).
(3) Auditor Notes-interview with Lucy May, Facility Director.
(4) Auditor Notes-interview with Cora Crenshaw, Social Services Coordinator (staff member responsible for conducting PREA orientation during intake).
(5) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.
(6) Random Resident Interviews (6 of 8 residents interviewed were aware of the availability of confidential victim services and the procedure for accessing these services).

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.

This standard requires that the agency establish a method to receive third party reports of sexual abuse and sexual harassment and that information as to how the agency will receive third party reports will be made available to the public. After interviews and discussions with administrative staff and a review of the applicable policies it was determined that the PREA policy does not provide for a method to receive third party reports. Additionally, there is no information regarding third party reporting within the PREA information pamphlet. Administrative staff indicated that third party reports of allegations of sexual abuse and sexual harassment would be received and investigated. Six of eight residents interviewed were aware they could utilize third parties to report allegations of sexual abuse. Information regarding third party reports should be added to the PREA policy and the PREA information pamphlet. Information regarding how to report sexual abuse on behalf of a resident (third party reporting) should also be made available to the public. One common method of making this information publically available is to publish it on the agency website.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp. 7-8.
(2) PREA Information Pamphlet (does not address third party reports).
(3) Auditor Observation-Keeton Corrections Inc. Website (at the time of the audit there was no information concerning third party reporting posted on the website).
(4) Random Resident Interviews (6 of 8 residents interviewed were aware they could report allegations of sexual abuse by means of a third party).

Corrective Action Required:

(1) Revise the PREA policy to include third party reporting as a permitted method of reporting allegations of sexual abuse
(2) Train staff on the revised policy and document the training.
(3) Add information regarding third party reporting to the PREA information pamphlet.
(4) Provide refresher training to the resident population addressing the revisions to the PREA pamphlet.
(5) Add information as to how to report allegations of sexual abuse on behalf on a resident to the agency website or otherwise make the information accessible to the public.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy to include third party reporting as a permitted method of reporting allegations of sexual abuse.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Upon review it was determined that language had been added to the PREA policy that staff will receive anonymous reports and reports from third parties. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 7.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Trian staff on the policy revisions and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016. The memorandum documented that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Add information regarding third party reporting to the PREA information pamphlet.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed the PREA pamphlet distributed to residents upon arrivalat the facility. Upon rev iew it was determined that language had been added to the PREA policy that staff will receive anonymous reports and reports from third parties. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) PREA Information Pamphlet (revised).

(4)Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Provide refresher training to the resident population addressing the revisions to the PREA pamphlet.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
Effective July 28, 2016 incoming residents were informed of the availability of third party reporting durin g the orientation process. Based on the short-term nature of the population all of the current residents of the facility have received orientation since July 28, 2016. Thu s, all current residents of the facility have been informed of the availability of th ird party reporting. This was confirmed by Byron Jasis in an email dated November 8, 2016. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Email from Byron Jasis dated November 8, 2016.

(5) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Add information as to how to report allegations of sexual abuse on behalf of a resident to the agency website or otherwise make the information accessible to the public.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 25, 2016 the auditor reviewed the Keeton Corretions Inc. web page. Information regarding how to report PREA-related incidents has been added to the web site. The facility is now in compliance with this corrective action item and the standard in genera l.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Email from Byron Jasis dated August 25, 2016 with a link to the Keeton Corrections web page.
(2) Auditor review-Keeton Corrections web page-November 8, 2016.

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.

This standard requires that all agency staff report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in any facility. The facility reports that within the preceding 12 months there were no incidents in which staff received and reported knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment within a facility. Based on interviews and discussions with administrative staff and a review of the applicable policies and practices, the auditor notes that the facility has taken substantial steps toward compliance with the requirements of this standard. There are some compon enets of the standard that are not provided for within the PREA policy. The provions of the standard that have been omitted from the policy have similarly been omitted as matters of practice. The PREA policy requires that all staff immediately report all knowledge, suspicions, or information of an incident of "sexual offense" within a Keeton Corrections, Inc. facility. The PREA policy defines sexual offense as " any behavior or act of a sexual nature directed toward an offender by a staff member, visitor, or other offender. This includes completed, attempted, threatened or requested acts, including sexual abuse, sexual harassment, voyeurism, sexual contact, contact of a sexual nature or implication, obscenity, and unreasonable invasion of privacy. The term sexual offense also includes conversations or correspondence, which suggest a romantic or sexual relationship between an offender and a staff member." For the purposes of the PREA policy only, "staff member" means full-time, part-time and interim employees, interns, students, volunteers, and contractors doing business on a recurring basis with Keeton Corrections, Inc. Since the behavior which constitutes "sexual offense" includes sexual abuse and sexual harassment (as defined within Standard 115.6) this provision of the PREA policy is consistent with the requirements of this standard. The standard further requires that staff are required to report sexual abuse or sexual harassment that has occurred at any facility, whether or not the facility is a part of the agency. The PREA policy limits the duty to report to incidents that occurred within a Keeton Corrections, Inc. facility. The standard further requires that the duty to report extends to incidents of retaliation against residents or staff who have reported sexual abuse or sexual harassment and to incidents of staff neglect or violation of responsibilities that may have contributed to an incident of retaliation. The PREA policy imposes a duty to report staff neglect but does not extend the duty to report to acts of retaliation or acts of violation of responsibilities. The PREA policy does impose the duty of confidentiality and limits disclosure of information to that necessary for treatment, investigative, or management decisions. The standard requires that the designated facility investigator be notified of the incident. This requirement has been incorporated into the PREA policy. The component of the standard imposing the duty to report to medical and mental health practitioners is not applicable to the facility since the facility does not employ medical or mental health staff. Additionally, the provision of the standard imposing the duty to report allegations involving persons under 18 or vulnerable adults does is not applicable to the facility since the facility does not house minors or vulnerable adults. The PREA policy should be revised to conform with the requirements of the standard.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexaul Abuse and Assault and PREA, p.3, pp. 8-9, p. 11.
(2) Staff Roster (demonstrates no medical or mental health practitioner employed at facility).
(3) Auditor Notes-Interview with Lucy May, Facility Director.
(4) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Amend the PREA policy to add language extending the duty to report to include incidents occurring at any facility within or outside of the agency.
(2) Amend the PREA policy to extend the duty to report to acts of retaliation.
(3) Amend the PREA policy to extend the duty to report to acts of violation of responsibilities.

(4) Train staff on the revised policies and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Amend the PREA policy to add language extending the duty to report to include incidents occurring at any facility within or outside of the agency.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language has been added to the policy extending the duty to report to incidents occurring at any facility within or outside the agency. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 9.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Amend the PREA policy to extend the duty to report to acts of retaliation.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added to the policy extending the duty to report to acts of retaliation. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 12.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director
(B) Task- Amend the PREA policy to extend the duty to report to acts of violation of responsibilities.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added to the policy extending the duty to report to acts of violation of responsibilities. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 12.

(4) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Train staff on the revised policies and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016. The memorandum documented that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

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.

This standard requires that an agency take immediate action when it learns that a resident is subject to a substantial risk of imminent sexual abuse. The facility reports that there were no incidents within the preceding 12 months prior to the audit in which it was learned that a resident was subject to a substantial risk of imminent sexual abuse. The PREA policy includes a provision that when it is learned that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident. This is consistent with the requirements of the standard. Based on interviews and discussions with administrative staff, it was confirmed that if a future incident occurred in which it was learned that a resident was subject to a substantial risk of imminent sexual abuse, the facility would take immediate action as required by the standard.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 7.
(2) Auditor Notes-Interview with Lucy May, Facility Director.
(3) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

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 Mobile Community Services Center reports that there were no incidents within the preceding 12 months in which the facility received information that a resident was sexually abused while at another facility. Additionally, the Mobile Community Services Center reports that there were no incidents within the preceding 12 months in which the facility was notified by another facility that a former resident had been sexually abused while at the Mobile Community Services Center. The standard requires that if information is recived at a facility that a current resident was sexually abused while at another facility, the facility receiving the information will report these allegations to the facility where the abuse was reported to have occurred within 72 hours of receiving the information. Under the PREA policy, if information is reported to the Mobile Community Services Center that a current resident was sexually abused while at previous facility it will notify the head of the facility where the incident was reported to have occurred within 72 hours of receipt of the information. The PREA policy also requires that if the Mobile Community Services Center receives information from another facility that a former resident was sexually abused while at the Mobile Community Services Center, this allegation will be investigated. These provisions are consistent with the requirements of the standard. Based on interviews and discussions with administrative staff, it was confirmed that if information was recived that a resident of the Mobile Community Services Center had been sexually abused while confined at a previous facility, the head of the facility where the abuse was alleged to have occurred would be notified. Additionally, during the course of interviews and discussions with administrative staff, it was confirmed that if information was received from another facility that a former resident of the Mobile Community Services Center had been sexually abused while housed at the Mobile Community Services Center, this allegation would be investigated.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 9.
(2) Auditor Notes-Interview with Lucy May, Facility Director.
(3) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility reports that there have been no incidents within the preceding 12 months in which staff were required to respond to the scene of a sexual assault. The standard requires that staff responding to the scene of a sexual abuse incident shall separate the alleged victim and abuser, and preserve and protect the crime scene until steps can be taken to collect evidence. If the incident occurs within a time period that still allows for the collection of physical evidence, the responding staff member shall request that the alleged victim not take any actions that coud destroy physical evidence. These actions include washing, brushing teeth, changing clothes, urinating, defecting, smoking, drinking, or eating. Additionally, if the abuse occurred within a time period that still allows for the collection of physical evidence, the responding staff member shall ensure that the alleged abuser does not take any action that could destroy physical evidence. These actions include washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first responding staff is not a security staff member, the staff member shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff. Each of these provisions has been incorporated into the PREA policy except the componenet of the standard requiring first responders who are not security staff to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff. This component of the standard should be incorporated into the PREA policy. Interviews and discussions with administrative staff confirmed that this component of the standard is not within the current PREA policy and that potential responding non-security staff have not been trained on this provision of the standard.

Policy, Materials, Interviews and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p.8.
(2) Auditor Notes-Interview with Lucy May, Facility Director.
(3) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Amend the PREA policy to include a provision requiring first responding staff that are not security staff to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.
(2) Train staff on the revised polcy and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Amend the PREA policy to include a provision requiring first responding staff that are not security staff to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and As sault and PREA. Language has been added to the policy stating that first responding staff that are not security staff shall request th e alleged victim not take any actions that could destroy evidence and then notify security staff. The facility is now in comp liance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corretions Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 8.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Train staff on the revised polcy and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016. The memorandum documented that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

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.

This standard requires the facility to develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators and facility leadership. The facility reports that in

the 12 months preceding the audit, there have been no allegations of sexual abuse. Accordingly, there have been no instances in which staff actions were coordinated in response to an incident of sexual abuse. The PREA policy specifies that first responding staff will separate the victim and abuser, secure the scene, preserve and collect physical evidence, request the victim not take actions that could destroy physical evidence, ensure the abuser does not take actions that coud destroy physical evidence, and restrict traffic entering the scene. Investigators are authorized to enter the scene as needed to carry out their duties. The Facilty Director is responsible for arranging for the resident to be transported to a medical facility for treatment and forensic medical examination and ensuring first responder duties have been carried out. The PREA policy does not address the role of medical and mental health practitioners since the facilty does not have any medical or mental health staff. These provisions of the PREA policy serve the funtions of a written plan coordinating the fucntions of the various staff in responding to an incident of sexual abuse. Thus, the applicable provisions of the PREA policy meet the requirements of the standard. During interviews and discussions with administrative staff, it was confirmed that if an actual incident of sexual abuse occurred, the actions of staff would be coordinated in accordance with the requirements of the standard.

Policy, Materials,Interviews, and other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp. 8-9.

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.

This standard is not applicable to the Mobile Community Services Center. The facility is a private, "at will" employer not involved in a collective bargaining process. This information was confirmed during interviews and discussions with administrative staff.

Policy, Materials, Interviews and Other Evidence Reviewed:
(1) Keeton Corrections Inc.-Mission Statement.
(2) Pre-Audit Questionaire.
(3) Auditor Notes - Interview with Lucy May, Facility Director.
(4) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility reports that there have been no reported incidents of sexual abuse or sexual harassment during the preceding 12 months. Accordingly, there have been no incidents requiring a monitoring period to protect residents or staff from retaliation. The standard requires that a policy be established to protect all staff and residents who report sexual abuse or sexual harassment, or who cooperate with sexual

abuse or sexual harassment investigations, from retaliation. The standard also requires that a designated staff member shall be responsible for monitoring retaliation. The monitoring period shall occur for at least 90 days and may terminate if the allegation is determined to be unfounded. These provisions have been incorporated into the PREA policy which is consistent with the requirements of the standard. The designated staff member for monitoring retaliation is the Social Services Coordinator, a senior administrative position at the facility. During interviews with administrative staff it was confirmed that the requirements of the standard would be met in the event of an incident of retaliation.

Policy, Materials, Interviews and Other Documents Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 11, Item K.
(2) Auditor Notes - Interview with Lucy May, Facility Director.
(3) Auditor Notes - Interview with Cora Crenshaw, Social Services Coordinator.

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 reports there have been no allegations of sexual abuse or sexual harassment during the preceding 12 months. Accordingly, there have been no administrative or criminal investigations into allegations of this type. Interviews and discussions with administrative staff members confirm that the facility has taken substantial steps toward compliance with the requirements of this standard but there is a lack of clarity regarding the specific role of the facility/agency in conducting administrative investigations as well as a lack of clarity as to the specific role of the Baldwin County Sheriff's Office in investigating allegations of sexual abuse and sexual harassment.

The standard requires that all sexual abuse and sexual harassment investigations conducted at the agency level be done promptly, thoroughly, and objectively for all allegations including those resulting from anonymous and third party sources. When sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations as outlined in Standard 115.234. Duties of the investigator include gathering and preserving direct and circumstantial evidence, including any DNA evidence and any available electronic monitoring data. Investigators shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the agency should conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness shall not be determined by the persons status as resident or staff. An agency may not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation into such an allegation.

In the case of administrative investigations, efforts shall be made to determine whether staff actions or failures to act contributed to the abuse; and shall be documented in written reports describing the physical and testimonial evidence, the reasoning behind credibility statements, and investigative facts and findings.

Criminal investigations shall be documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of documentary evidence where feasible. Substantaiated allegations of conduct that appear to be criminal shall be referred for prosecution. The agency shall maintain all administrative and criminal investigative reports for as long as the abuser is incarcerated or employed plus an additional five years. When outside agencies investigate sexual abuse, the facility shall endeavor to remain informed about the progress of the investigation.

The PREA policy makes reference to administrative investigations and requires that facility-level investigators receive training in accordance with the requirements of Standard 115.234. The PREA policy aslo contains a provision that the investigators from the "Jacksonville Sheriff''s Office" shall be permitted to enter the scene of a sexual abuse incident. The facility has an informal arrangement with the Baldwin County Sheriff's Office that personnel are permitted to enter the scene of sexual abuse incidents but the the policy does not specify which incidents will be investigated at the facility level and which incidents will be investigated by the Baldwin County Sheriff's Office. Additionally, the PREA policy does not incorporate the various investigative duties as outlined above when incidents are investigated at the facility level. These issues need to be clarified and the policy needs to be revised accordingly. The retention schedule for administrative and criminal investigative reports should also be incorporated into the PREA policy.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 5, p.8, p.10.
(2) Auditor Notes-Interview with Lucy May, Facility Director.
(3) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Review PREA Policy and determine specific criteria for facility-level sexual abuse and sexual harassment investigations as opposed to investigations conducted by the Baldwin County Sheriff's Office.
(2) Obtain a signed MOU with the Baldwin County Sheriff's Office specifying the specific investigative services they will provide to the facility.
(3) Revise the PREA policy to include the duties of facility-level investigators based on the investigative duties outlined above
(4) Revise the PREA policy to include the retention schedule for administrative and criminal investigative reports.
(5) Revise the PREA policy at p. 8, (3), (d) replacing "Jacksonville Sheriff's Office" with "appropriate law enforcement agency" (this is an agency-level policy-the appropriate law enforcement agency will vary based on the location of the facility).
(6) Revise the PREA policy to add a retention schedule for investigative reports.
(7) Train staff on the policy revisions and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director
(B) Task- Review the PREA Policy and determine specific criteria for facility-level sexual abuse and sexual harassment investigations as opposed to investigations conducted by the Baldwin's County Sheriff's Office.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language has been added to the policy indication investigations into incidents rising to the level of criminal behavior shall be referred to the appropriate law enforcement agency (Baldwin County Shariff's Office). Investigations into incidents that don't rise to the level of criminal behavior shall be conducted at the facility level. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 10.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Obtain a signed MOU with the Baldwin County Sheriff's Office specifying the investigative services they will provide to the facility.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added indicating that sexual abuse and sexual harassment investigations shall initially be conducted at the facility level by trained Keeton Corrections, Inc. staff. Conduct rising to the level of criminal behavior shall be referred to outside law enforcement agencies. On December 19, 2016 the auditor reviewed an email from Jerica Poellnitz confirming the facility continues to operate under an informal agreement with the Baldwin County Sheriff's Office under which the sheriff's office will provide law enforcement services to the facility. The facility attempted to enter into a formal Memorandum of Understanding (MOU) between the facility and the sheriff's office but the sheriff's office declined to enter into a formal agreement. The Baldwin County Sheriff's office mission statement was presented which confirmed that the sheriff's office would provide law enforcement services on a county-wide basis. Although a formal agreement with the sheriff's office is desirable it is not essential in demonstrating compliance with the standard. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 10.
(2) Baldwin County Sheriff's Office Mission Statement
(3) Email from Jerica Poellintz dated December 19, 2016 documenting the attempt to enter into a MOU with the Baldwin County Sheriff's Office.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy to include the duties of facility-level investigators based on the investigative duties outlined above.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language had been added to the policy outlining the duties of facility investigators as listed in accordance with this standard. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 10.

(4) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy to include the retention schedule for administrative and criminal investigative reports.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language had been added to the policy specifying the retention schedule for administrative and criminal investigative reports. The facility is now in compliance with the corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 10.

(5) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy at p. 8, (3), (d) replacing "Jacksonville Sheriff's Office" with "appropriate law enforcement agency" (this is an agency-level policy-the appropriate law enforcement agency will vary based on the location of the facility).
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1(formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added to the policy replacing "Jacksonville Sheriff's Office" with "appropriate law enforcement agency." The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 9.

(6)Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and Facility Director.
(B) Task- Revise the PREA policy to add a retention schedule for investigative reports.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1(formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added to the policy specifying the retention schedule for investigative reports. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 10.

(7)Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and Facility Director.
(B) Task- Train staff on the policy revisions and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Memorandum from Lucy May dated December 1, 2016 documenting facility staff had been trained in the revised policy.

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.

This standard requires that the agency shall impose no standard higher than a preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. This requirement has been incorporated into the PREA policy. The facility reports that there have been no allegations of sexual abuse or sexual harassment during the 12 months preceding the audit. As a result, there have been no incidents in which a determination was made as to whether or not an incident of sexual abuse or sexual harassment was substantiated. Based on interviews and discussions with administrative staff, it was confirmed that if a future incident occurred which required that a determination be made as to whether or not an allegation of sexual abuse or sexual harassment was substantiated, the evidentiary standard that would be applied would be no higher than a preponderance of evidence.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 7.
(2) Auditor Notes-Interview with Lucy May, Facility Director.
(3) Auditor Notes-discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

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.

The facility reports there have been no allegations of sexual abuse within the preceding 12 months. Accordingly, there have been no instances in which the facility reported the final outcome of an investigation to a resident alleging sexual abuse. This standard requires the agency to inform residents alleging sexual abuse whether the allegation was substantiated, unsubstantiated, or unfounded. This requirement applies to both investigations conducted by the agency or by an outside agency. Following the resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident whenever the staff member is no longer posted within the resident's unit, whenever the staff member is no longer employed at the facility, or whenever the facility learns that the staff member has been indicted on a charge related to sexual abuse within the facility. These notifications need not be made when it has been determined that the allegation is unfounded. Additionally, following a resident's allegation they have been sexually abused by another resident, the agency shall inform the alleged victim whenever the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility, or when the agency learns the alleged abuser has been convicted on a charge related to sexual abuse within the facility. All such notifications or attempted notifications shall be documented. The agency obligation to report shall terminate if the resident making the allegation is released from the custody of the agency. The agency has incorporated the notification requirements within the standard into the PREA policy. During the course of interviews and discussions with administrative staff, it was confirmed that if a future incident occurred requiring that a resident be notified of any of the above listed events, the resident would be notified in accordance with the requirements of this standard.

Policy, Materials, Interviews and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 10
(2) Auditor Notes-Interview with Lucy May, Facility Director.
(3) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

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.

The facility reports there have been no allegations a staff member has violated the agency sexual abuse or sexual harassment policies during the preceding 12 months. Accordingly, there have been no instances in which it was found that a staff member violated agency sexual abuse or sexual harassment policies and no resulting disciplinary sanctions against staff. The standard requires that staff shall be subject to disciplinary sanctions, up to and including termination for violating agency sexual abuse and sexual harassment policies. The presumptive disciplinary sanction for staff who have engaged in sexual abuse is termination. Disciplinary sanctions for staff violating agency policies relating to sexual abuse or sexual harassment other than actually engaging in sexual abuse, shall be commensurate with a number of specific factors. These factors include the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed on other staff with similar histories who committed comparable offenses. All terminations for violations of sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law

enforcement agencies and the appropriate licensing authority, if applicable. Neither the current personnel handbook containing the employee conduct policy or the PREA policy contain a provision that the apprpropriate licensing authority, if applicable, will be notified. This language should be added to the PREA policy or the personnel handbook to comply with this componenet of the standard. The notification to law enforcement is not required if it is clear the activity was not criminal. The Keeton Corrections Inc. employee conduct policy published in the personnel handbook provides for the termination of staff who have engaged in serious misconduct such as violation of agency sexual abuse policies. Lesser sanctions such as suspension may be administered for violations that do not rise to the level of sexual abuse. This is consistent with the rquirements of the standard. Under the PREA policy, allegations of sexual abuse that may rise to the level of criminal conduct shall be referred to the Florida State Police. This language should be replaced with a more general reference such as "the appropriate law enforcement agency". The facility currently has an informal agreement with the Marion County Sheriff's Office to conduct criminal investigations.

Policy, Materials, interviews, and Other Evidence Reviewed:

(1) Personnel Handbook, Employee Conduct and Disciplinary Action, p. 24.
(2) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 9.
(3) Mobile-Statement of Work, pp. 16-18 (professional standards for employees).

Corrective Action Required:

(1) Revise the PREA policy at p. 9 replacing "Florida State Police with " appropriate law enforcement agency" (this is an agency-level policy, the appropriate law enforcement agency will vary based on the location of the facility).
(2) Add language to the PREA policy or the Personnel Handbook that violations of the sexual abuse or sexual harassment policies by licensed employees shall be referred to the applicable licensing authority.
(3) Train staff in the revised policies and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy at p. 9 replacing "Florida State Police with " appropriate law enforcement agency" (this is an agency-level policy, the appropriate law enforcement agency will vary based on the location of the facility).
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language has been added to the policy replacing "Florida State Police" with "appropriate law enforcement agency." The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 9.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Add language to the PREA policy or the Personnel Handbook that violations of the sexual abuse or sexual harassment policies by licensed employees shall be referred to the applicable licensing authority.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance. Language has been added to the policy stating that violations of of sexual abuse or sexual harassment policies by licensed employees shall be referred to the applicable licensing authority. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance (revised) at page 2.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Train staff in the revised policies and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016 documenting that facility staff have been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

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.

The facility reports there have been no allegations of sexual abuse or sexual harassment within the preceding 12 months. Accordingly, there have been no investigative findings that a contractor or volunteer has engaged in sexual abuse. Additionally, the Mobile Community Services Center has not utilized contractors or unsupervised volunteers to provide services within the preceding 12 months. Supervised volunteers are utilized to provide religious services and financial planning counseling. It is strongly recommended that these volunteer staff receive orientation and training in PREA related topics since they do have contact with residents. The standard further requires that contractors or volunteers who engage in sexual abuse shall be prohibited from contact with residents. Additionally, the incident shall be reported to law enforcement unless the activity was clearly not criminal. The incident shall also be reported to the applicable licensing authority if the contractor or volunteer delivers a service that requires licensing. The facilty shall take appropriate remedial measures and consider whether to prohibit further contact with residents in cases of violation of agency sexual abuse or sexual harassment policies that do not rise to the level of actual sexual abuse. The Keeton Corrections Inc. employee conduct policy published in the personnel handbook provides for the termination of staff who have engaged in serious misconduct such as violation of agency sexual abuse policies. Lesser sanctions such as suspension may be administered for violations that do not rise to the level of sexual abuse. This is consistent with the rquirements of the standard. Under the PREA policy, allegations of sexual abuse that may rise to the level of criminal conduct shall be referred to the Florida State Police. The facility currently has an informal agreement with the Marion County Sheriff's Office to conduct criminal investigations. Both the PREA policy and the policy addressing the use of volunteers state that volunteers are held to the same standards of conduct as agency employees. The PREA policy also provides that contractors are held to the same standard of conduct as agency employees. Neither the PREA policy or the policy addressing the use of volunteers require notification to the applicable licensing authority if the contractor or volunteer provides a service to the facility that requires the provider to be licensed, and the contractor or volunteer has engaged in sexual abuse or sexual harassment. Language incorporating this component of the standard should be added to policy. Based on interviews and discussions with administrative staff, it was confirmed that this provision of the standard was not addressed within either the PREA policy or the policy governing the use of volunteers.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 3, p. 9.
(2) Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance, p. 22.
(3) Auditor Notes-Interview with Lucy May, Facility Director.
(4) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:
(1) Revise the PREA policy at p. 9 replacing "Florida State Police" with "appropriate law enforcement agency" (this is an agency-level policy, the appropriate law enforcement agency will vary based on the location of the facility).
(2) Add language to the PREA policy that the appropriate licensing authority will be notified if contractors deliverin g services to the facility must be licensed to deliver the service and the contractor has engaged in sexual abuse or sexual harassment.
(3) Add language to the policy addressing the use of volunteers that the appropriate licensing authority will be notified if volunteers delivering services to the facility must be licensed to deliver the service and the volunteer has engaged in sexual abuse or sexual harassment.
(4) Train staff in the revised policies and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Revise the PREA policy at p. 9 replacing "Florida State Police" with "appropriate law enforcement agency" (this is an agency-level policy, the appropriate law enforcement agency will vary based on the location of the facility).
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and A ssault and PREA. Language has been added to the policy replacing "Florida State Police" with "appropriate law enforcement agency." The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at page 9.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Add language to the PREA policy that the appropriate licensing authority will be notified if contractors delivering services to the facility must be licensed to deliver the service and the contractor has engaged in sexual abuse or harassment.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordin ation, and Severance. Language has been added to the policy that the appropriate licensing authority will be notified if contractors delivering services to the facility hold a license to deliver the services and the contractor has engaged in sexual abuse or sexual harassment. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance (revised) at page 2.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Add language to the policy addressing the use of volunteers that the appropriate licensing authority will be notified if volu nteers delivering services to the facility must be licensed to deliver the service and the volunteer has engaged in sexual abuse or s exual harassment.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Coordination, and Severance. Language has been added to the policy that the appropriate licensing authority will be notified if volunteers d elivering services to the facility hold a license to deliver the services and the volunteer has engaged in sexual abuse or sexual harassment. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 2.9, Recruitment, Training, Volunteer Cooerdination, and Severance (revised) at page 2.

(4) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Train staff in the revised policies and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum form Lucy May dated December 1, 2016 documenting facility staff had been trained in the revised policy.

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 reports that have been no incidents during the preceding year in which residents have been found guilty pursuant to the resident disciplinary mechanism for resident-to-resident sexual abuse. Additionally, the facility reports that during the preceding 12 months there have been no incidents in which a resident has been found guilty pursuant to a criminal proceeding, of resident-to-resident sexual abuse. The standard requires that residents who have been found guilty of resident-to-resident sexual abuse pursuant to the resident disciplinary mechanism or prosection in criminal court, shall be subject to disciplinary sanctions. The sanctions imposed upon the resident under the resident disciplinary mechanism shall be commensurate with the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with comparable histories. The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. For major disciplinary

infractions the facility utilizes the applicable provisions of the disciplinaty process promulgated by the Federla Bureau of Prisons. Under this system, there are various infractions that encompass conduct constituting resident-to-resident sexual abuse and defined sanctions that may be imposed when residents are found guilty of these infractions. The disciplinary mechanism includes due process protections within the hearing process. When penalties are considered, factors specific to the resident such as his or her prior disciplinary history and any relavent mental heath issues faced by the resident are taken into account. This is consistent with the requirements of the standard. Interviews and discussions with administrative staff confirmed that if a future incident occurred in which a resident received sanctions for engaging in resident-to–resident sexual abuse, the case would be handled in accordance with the requirements of this standard.

Policy, Materials, and Other Evidence Reviewed:

(1) Mobile -Statement of Work, p. 72 (disciplinary sanctions to be commensurate with the nature of the infraction).
(2) Federal Bureau of Prisons, Incident Report Codes.
(3) Federal Bureau of Prisons, Statement of Programs-Inmate Discipline.
(4) Auditor Notes-Interview with Lucy May, Facility Director.
(5) Auditor Notes-Interview with Byron Jasis, Assistant Director, Keeton Corrections - Paducah.

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.

This standard requires that victims of sexual abuse receive emergency medical treatment and crisis intervention services. The facility reports there have been no allegations of sexual abuse during the preceding 12 months. Accordingly, there have been no instances in which victims of sexual abuse have received emergency medical treatment or crisis intervention services as a result of sexual abuse. The victim shall bear no costs for the delivary of these services. The PREA policy contains specific provisions requiring victims of sexual abuse be transported to a health care facility for emergency medical treatment and forensic medical examination if appropriate. The policy further provides that mental health treatment and care will be provided to the victim. Medical and mental health services provided to the victim shall be delivered without cost to the victim. This is consistent with the requirements of the standard. The facility maintains a Memorandum of Understanding (MOU) with the Lighthouse Counseling Center, Inc. (LCC) to provide advocacy, counseling, and follow-up services to victims of sexual abuse. The MOU does not specify that these services include coordination of sexual assault medical forensic examinations but this service is listed on the Lighthouse web page. The MOA does not address emergency medical care or specify that it will assist with the coordination of medical services for victims of sexual abuse. The MOU does specify that LCC will provide crisis intervention services to victims of sexual abuse. The pre-audit questionnaire indicates that emergency medical services including sexual assault forensic medical examinations will be provided by USA Children and Women's Hospital (USA) in Mobile, Alabama. The facility should obtain a Memorandum of Understanding (MOU) with USA that includes language indicating the hospital will provide emergency medical treatment to include the administration of sexual assault forensic medical examinations to victims of sexual abuse. In accordance with Standard 115.221 the MOU should include language that the hospital will adhere to the DOJ National Protocol for Sexual Assault Forensic Medical Examinitions.

Policy, materials and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp. 8-9.
(2) MOU between Keeton Corrections Inc. and LCC.
(3) Auditor Notes-Interview with Lucy May, Facility Director.
(4) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:

(1) Add language to the MOU between Keeton Corrections and LCC that specifies to what extent LCC will assist in providing access to medical care for victims.
(2) Obtain a MOU with USA Children and Women's Hospital specifying the hospital will provide emergency medical treatment (including sexual assault forensic medical examinations if appropriate) to victims of sexual abuse.

Corrective Action Required:

(1) Add language to the MOU between Keeton Corrections and CCI that specifies to what extent the CCI will assist in providing access to medical care for victims of sexual abuse.
(2) Clarify the MOU between Keeton Corrections and the CCI as to whether or not the CCI will assist in providing access to a SAFE (Sexual Assault Forensic Examination) program.
(3) Obtain a MOU with UAB Hospital specifying the hospital will provide emergency medical treatment (including sexual assault forensic medical examinations if appropriate) to victims of sexual abuse.

(1) Plan of Corrective Action/Deliverables:

(A) Assigned Staff-Byron Jasis and Facility Director.
(B) Task- Add language to the MOU between Keeton Corrections and Lighthouse Counseling Center (LCC) that specifies to what extent the LCC will assist in providing access to medical care for victims of sexual abuse.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On December 15, 2016 the auditor reviewed the most recent Memorandum of Understanding (MOU) between the facility and Ligh thouse Counseling Center (LCC) dated June 20, 2016. The MOU references a variety of services for victims of sexual abuse which are detailed on the LCC's web site. The web site confirms that sexual assault victims will be provided access to community-based medical services if needed. On December 19, 2016 Byron Jasis confirmed via email that LCC would coordinate with the USA Chidren and Women's Hospital as the community-based provider that would perform emergency medical treatment including SAFE examinations if warranted. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) MOU between the facility and Lighthouse Counseling Center (LCC) dated June 20, 2016.
(2) Email from Byron Jasis dated December 19, 2016 confirming the Children and Women's Hospital would emergency medical services including SAFE examinations when warranted.
(3) Lighthouse Counseling Services Web Site.

(2)Plan of Corrective Action/Deliverables:

(A) Assigned Staff-Byron Jasis and Facility Director
(B) Task- Clarify the MOU between Keeton Corrections and Lighthouse Counseling Center (LCC) as to whether or not LCC will assist in providing access to a SAFE (Sexual Assault Forensic Examination) program.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On December 15, 2016 the auditor reviewed the most recent Memorandum of Understanding (MOU) between the facility and Lightho use Counseling Center (LCC) dated June 20, 2016. The MOU references a variety of services for victims of sexual which are d etailed on the LCC's web site. The web site confirms that sexual assault victims will be provided access to community-based SAFE programs if needed. On December 19, 2016 Byron Jasis confirmed via email that LCC would coordinate with the USA Chidren and W omen's Hospital as the community-based provider that would perform the SAFE examinations if warranted. On December 19, 2016 the auditor reviewed an email from Jerica Poellnitz dated December 19, 2016 which documented the USA Children and Women's Hospital had been made aware of the DOJ National Protocol for Sexual Assault Forensic Medical Examinations. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) MOU between the facility and Lighthouse Counseling Center (LCC) dated June 20, 2016.
(2) Email from Byron Jasis dated December 19, 2016 confirming the Children and Women's Hospital would conduct SAFE examinations when warranted.
(3) Lighthouse Counseling Services Web Site.
(4) Email from Jerica Poellintz dated December 19, 2016 documenting that the Children and Women's Hospital had been made aware of the DOJ National Protocal for Sexual Assault Forensic Medical Examinations.

(3)Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and Facility Director
(B) Task- Obtain a MOU with USA Children and Women's Hospital specifying the hospital will provide emergency medical treatment (including sexual assault forensic medical examinations if appropriate) to victims of sexual abuse.

(C)Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 19, 2016 the auditor reviewed an email from Byron Jasis dated December 19, 2016. The email confirmed that USA Children and Women's Hospital would be utilized to provide emergency medical care (including sexual assault forensic medical examinations) for residents of the facility based on an informal agreement between the facility and the hospital. Although it is desirable to maintain a formal agreement between the facility and the hospital it is not essential in determining that the facility meets the requirements of the standard.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Email from Byron Jasis dated December 19, 2016 documenting the USA Children and Women's Hospital would provide emergency medical treatment to the facility.

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.

This standard requires the facility to provide a medical and mental health evaluation and treatment to residents who have been victimized by sexual abuse in any confinement facility. The types of programs and services that shall be provided are listed in in sections (b)-(h) of Standard 115.283. The facility reports there have been no allegations of sexual abuse during the preceding 12 months. Accordingly, there have been no instances in which a victim of sexual abuse received ongoing medical and mental health care as the result of being sexually abused. The standard requires medical and mental health evaluations and appropriate treatment for victims of sexual abuse. The level of services shall include, as appropriate, care and treatment for incidental pregnancy, and sexually transmitted disease. The standard of care shall be commensurate with the level care for similarly situated victims within the community and shall be delivered without cost to the victim. These components of the standard have been incorporated into the PREA policy. The facility operates under a Memorandum of Understanding (MOU) with the Lighthouse Counseling Services, Inc. (LCC) to provide services to sexual abuse victims from the facility. LCC is a rape and sexual abuse crisis center for the city of Ocala which will provide advocacy, counseling, and follow-up services to victims of sexual violence. There is no language within the MOU addressing medical or mental health evaluations or ongoing medical or mental health care and treatment for victims of sexual abuse. If LCC can coordinate referrals to service providers offering the types of post-incident medical and mental health care outlined in sections (b)-(h) of the standard, language to this effect should be added to the MOU. If LCC is unable to coordinate referrals of this type, the facility will need to make arrangements with specific providers to deliver the medical and mental heath services outlined in (b)-(h) of the standard. Based on interviews and discussions with administrative staff, it was

confirmed that should an actual incident of sexual abuse occur in the future, the victim would be afforded the services required under this standard.

Policy, Materials, Interviews and Other Evidence Reviewed:
(1) Keeton Corretions Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp. 8-9.
(2) MOU between Keeton Corrections, Inc. and Lighthouse Counseling Services, Inc. (LCC).
(3) Auditor Notes-Interview with Lucy May, Facility Director.
(4) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:
(1) Amend the MOU between Keeton Corrections, Inc. and LCC to address the provision of medical and mental health evaluations for victims of sexual abuse.
(2) Amend the MOU between Keeton Corrections, Inc. and LCC to address the delivery of follow-up medical and mental health care for victims of sexual abuse as outlined in Sections (b)-(h) of Standard 115.283.

This standard requires the facility to provide a medical and mental health evaluation and treatment to residents who have bee n victimized by sexual abuse in any confinement facility. The types of programs and services that shall be provided are listed in in sections (b)-(h) of Standard 115.283. The facility reports there have been no allegations of sexual abuse during the preceding 12 months. Accord ingly, there have been no instances in which a victim of sexual abuse received ongoing medical and mental he alth care as the result of being sexually abused. The standard requires medical and mental health evaluations and appropriate treatment for victims of sexual abuse. Th e level of services shall include, as appropriate, care and treatment for incidental pregnancy, and sexually transmitted disease. The standard of care shall be commensurate with the level care for similarly situated victims within the community and shall be delivered without cost to the victim. These components of the standard have been incorporated into the PREA policy. The facility operates under a Memorandum of Understanding (MOU) with the Lakeview Center Rape Crisis/Trauma Recovery Program (RCC) to provide services to sexual abuse victims from the facility. The RCC is a rape and sexual abuse crisis center for the city of Pensacola which will provide advocacy, counseling, and follow-up services to victims of sexual violence. Although the MOU between the agency/facility expressly states the MOU was written to provide services related to the implementation of PREA, there is no language within the MOU addressing medical or mental health evaluations or ongoing medical or mental health care and treatment. If the RCC can coordinate referrals to service providers offering the types of post-incident medical and mental health care outlined in sections (b)-(h) of the standard, language to this effect should be added to the MOU. If the RCC is unable to coordinate referrals of this type, the facility will need to make arrangements with specific providers to deliver the medical and mental heath services outlined in (b)-(h) of the standard. Based on interviews and discussions with administrative staff, it was confirmed that should an actual incident of sexual abuse occur in the future, the victim would be afforded the services required under this standard.

Policy, Materials, Interviews and Other Evidence Reviewed:
(1) Keeton Corretions Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp. 8-9.
(2) MOU between Keeton Corrections, Inc. and the RCC.
(3) Auditor Notes-Interview with Bridgette Bridgeforth, Facility Director.
(4) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

Corrective Action Required:
(1) Amend the MOU between Keeton Corrections, Inc. and the LCC to address the provision of medical and mental health evaluations for victims of sexual abuse.
(2) Amend the MOU between Keeton Corrections, Inc. and the LCC to address the delivery of follow-up medical and mental health care for victims of sexual abuse as outlined in Sections (b)-(h) of Standard 115.283.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and Facility Director.
(B) Task- Amend the MOU between Keeton Corrections, Inc. and the LCC to address the provision of medical and mental health evaluations for victims of sexual abuse.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 15, 2016 the auditor reviewed the most recent Memorandum of Understanding (MOU) between the facility and Lighthouse Counseling Center (LCC) dated June 20, 2016. The MOU references a variety of services for victims of sexual which are detailed on the LCC's web site. The web site confirms that sexual assault victims will be provided access to community-based medical and mental health services as needed. It is is desireable to include specific provisions within the MOU addressing the provision of medical and mental health evaluations but this is not essential in determining th at the facility meets the requirements of the standard. It is noted that the facility has included a specific provision within the PREA policy confirming an affirmative duty to provide any needed medical or mental h ealth treatment for victims of sexual abuse. The facility is now in compliance with this item of corrective action and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA, p.8.
(2) Memorandum of Understanding between the facility and the LCC dated June 20, 2016.
(3) Lighthouse Counseling Center Website.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and Facility Director.
(B) Task- Amend the MOU between Keeton Corrections, Inc. and the LCC to address the delivery of follow-up medical and mental health care for victims of sexual abuse as outlined in Sections (b)-(h) of Standard 115.283.
(C) Anticipated Completion Date-October 29, 2016.

Verification of Corretive Action Since the Audit:
On December 15, 2016 the auditor reviewed the most recent Memorandum of Understanding (MOU) between the facility and Lightho use Counseling Center (LCC) dated June 20, 2016. The MOU references a variety of services for victims of sexual which are detailed on the LCC's web site. The web site confirms that sexual assault victims will be provided access to community-based medical and mental health services as needed. It is is desireable to include specific provisions within the MOU addressing the delivery of follow-up medical and mental health care but this is not essential in determining that the facility meets the requirements of the standard. It is noted that the facility has included a specific provision within the PREA policy confirming an affirmative duty to provide any needed medical or mental health treatment for victims of sexual abuse The facility is now in compliance with this item of corrective action and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA, p.8.
(2) Memorandum of Understanding between the facility and the LCC dated June 20, 2016.
(3) Lighthouse Counseling Center (LCC) Website.

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.

This standard requires that post-incident reviews be conducted at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The standard requires that incidents of this type be conducted by a designated review team. The composition of the team is addressed at (c) of Standard 115.286. Specific functions of the team are listed in (d), (1)-(6) of the standard. The facilty reports that there have been no incidents of sexual sbuse, sexual harassment, or retaliation for reporting sexual abuse or sexual harassment over the past 12 months. The PREA policy includes a provision that provides for a sexual abuse incident review team. The PREA policy provides that in the event a sexual abuse incident occurred, it would be reviewed within 30 days of the incident by a team composed of upper-level management officials who will consider input from line supervisors, investigators, and medical and mental health practititioners. The facility reports there has not been an actual allegation of sexual abuse during the 12 months preceding the audit. Accordingly, there has been no subsequent need to empanel a post-incident review team. It was determined through interviews and

discussions with administrative staff that should an actual sexual abuse incident occur in the future, it will be reviewed by an incident review team in accordance with the requirements of the standard.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, pp.10-11.
(2) Auditor Notes-Interview with Lucy May, Facility Director.
(3) Auditor Notes-Interview with Karen Hall, Vice President/Operations.
(4) Auditor Notes-Interview with Terracina Davis, Quality Assurance Manager (agency-level) and Agency PREA Coordinator.
(5) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.

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.

This standard requires that data be collected and maintained regarding all sexual abuse allegations occurring within the agency. The facility reports that there were no incidents of sexual abuse, sexual harassment, or retaliation for reporting sexual abuse or sexual harassment during the preceding 12 months. This standard requires that uniform data regarding sexual abuse allegations within the agency is collected and maintained within the corporate office. The data is to be aggregated on an annual basis and submitted to the Deaprtment of Justice upon request. The agency reports there have been no reported allegations of sexual abuse for the past year. Based on interviews with administrative staff, it was determined that data regarding incidents of sexual abuse allegations have not been captured and compiled because there have been no reportable incidents to date. Although there have been no reportable incidents, the data should still be captured even if the value of the number of reportable incidents is zero. The collection and publication of this data on an annualized basis creates a baseline by which the agency can compare the annualized data for one year to the data collected for subsequent years. This enables stakeholders to conduct an analysis of trends over time. Although there is a polcy provision in the PREA policy at p. 12 for the collection of this data, it has not been collected as a matter of practice.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 12.
(2) Auditor Notes- Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.
(3) Auditor Notes- Interview with Karen Hall, Vice President/Operations.
(4) Auditor Notes-Interview with Terracina Davis, Quality Assurance Manager (agency level) and Agency PREA Coordinator.

Corrective Action Required:
(1) Set up an agency-level data base recording the number of allegations of sexual abuse allegations from the individual facilities within the agency (utilizing the definitions within Standards 115.5 and 115.6).
(2) The data base should be designed so that the collected data can be aggregated based on an annualized reporting period such as calendar year or fiscal year.
(3) Ensure the collected data is securely stored and provided to the DOJ upon request.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Set up an agency-level data base recording the number of allegations of sexual abuse from the individual facilities within the agency (utilizing the definitions within Standards 115.5 and 115.6).
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On August 11, 2016 the auditor reviewed the monthly PREA Report Form the agency designed to collect data regarding allegations of sexual abuse occurring at facilities within the agency. The agency has initiated a centralized data base designed to capture allegations of sexual abuse occurring within any of the individual facilities within the agency. This was confirmed in an email from Byron Jasis dated November 9, 2016. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Email from Byron Jasis dated November 9, 2016 confirming the establishment of the data base designed to capture allegations of sexual abuse occurring at any of the facilities within the agency.
(2) PREA Report Form.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Design the data base so that the collected data can be aggregated based on an annualized reporting period such as calendar year or fiscal year.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
The data base was designed to enable the data to be aggregated on an annualized basis. The agency will be using a reporting y ear begining on August 1 and ending on July 31. This was confirmed in an email from Byron Jasis dated November 9, 2016. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Email from Byron Jasis dated November 9, 2016 confirming the data base is designed to aggregate data on an annualized basis.

(3) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Ensure the collected data is securely stored and provided to the DOJ upon request.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and As sault and PREA. The policy has been amended to include a provision that the collected data shall be securely stored and made available to the DOJ upon request. On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained on the revised policy. The facility is now in compliance with this corrective actio n item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (amended) at page 12.
(2) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained on the revised policy.

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.

Under the requirements of this standard, the data collected in accordance with Standard 115.187 will be utilized to assess and improve the

effectiveness of the agency's sexual abuse prevention, detection, and response policies, practices, and training including: identifying problem areas; taking corrective action on an on-going basis; and preparing an annual report of its findings and corrective action for each facility and the agency as a whole. The contents of the report will include a comparison of the current year data with data and corrective actions collected from the previous year as a means of assessing the agency's progress in addressing sexual abuse. The report shall be available to the public by publication on the agency website. The requirements of this standard cannot be met until the the data collection system outlined in standard 115.287 is implemented. Although the PREA policy contains a provision regarding the collection and storage of data, the policy does not address all of the requirements outlined at Section (a) of Standard 115.288. Based on interviews and discussions with administrative staff, it was determined that the agency efforts toward the the collection, storage, and publication of sexual abuse data are in the beginning stages but significant effort will be required to bring the agency into compliance with Standards 115.287, 115.288, and 115.289.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p. 12.
(2) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.
(3) Auditor Notes-Interview with Karen Hall, Vice President/Operations.

Corrective Action Required:

(1) Amend the PREA policy at p. 12 to include a provision that the agency will review the data collected and utilize the information to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training.
(2) Amend the PREA policy at p.12 and replace "Bureau of Prisons website " with "Keeton Corrections Inc. website."
(3) Amend the PREA policy at p. 12 and add a provision for the publication of an annual report based on the review of the data which incudes the findings and corrective action for each facility and the agency as a whole, and a comparison with previous years findings (beginning in year two of the process).
(4) Train staff in the policy revisions and document the training.
(5) Publish the report on the agency (Keeton Corrections, Inc.) website.
(6) Ensure any personal identifying information is not included in the published report.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Amend the PREA policy at p. 12 to include a provision that the agency will review the data collected and utilize the information to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA. Language has been added to the policy that states that the agency will review the data collected regarding incidents of sexual abuse and utilize the information to assess and improve the effectiveness of the agency sexual abuse prevention, detection, and response policies, practices, and training. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (amended) at page 12.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Amend the PREA policy at p.12 and replace "Bureau of Prisons website " with "Keeton Corrections Inc. website."
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse, and Assault and PREA. Language has been added to the policy replacing "Bureau of Prisons website" with "Keeton Corrections Inc. website." The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA (revised) at pp.12-13.

(3) Plan of Corrective Action/Deliverables:

(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Amend the PREA policy at p. 12 and add a provision for the publication of an annual report based on the review of the data which incudes the findings and corrective action for each facility and the agency as a whole, and a comparison with previous years findings (beginning in year two of the process).
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language has been added to the policy stating the agency shall publish an annual report based on the review of the data colleted regarding allegations of sexual abuse occurring at any of the facilities within the agency. The report shall include the find inga and corrective action for each facility and the agency as a whole. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and assault and PREA (revised) at pp. 12-13.

(4) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Train staff in the policy revisions and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Memorandum from Lucy May dated December 1, 2016 documenting that facility staff had been trained in the revised policy.

(5) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Publish the report on the agency (Keeton Corrections, Inc.) website.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language has been added to the policy stating that the annual report generated as a result of the annulized data co lletion would be published on the agency website. The first annualized reporting period started on August 1, 2016 and will end on July 31, 2017. The annual report reflecting this collection period shall be published during the month of August in 2017. This was confirmed in an email from Byron Jasis dated November 9, 2016. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:
(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at pp. 12-13.
(2) Email from Byron Jasis dated November 9, 2016.

(6) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Ensure any personal identifying information is not included in the published report.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22), Sexual Abuse and Assault and PREA. Language has been added to the policy stating that when the annual report is published any identifying information would not be included in the report. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at page 13.

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.

This standard addresses the requirements for the storage, publication, and and destruction of sexual abuse data. The requirements of this standard cannot be met until the requirements of Standard 115.287 have been implemented. The data collected in accordance with Standard 115.187 shall be securely maintained. Before the data regarding sexual abuse is made available to the public, any personal identifiers shall be removed. This standard requires that the the collected information be securely stored and maintained for at least 10 years after the date of collection, that the data does not contain personal identifying information, and that the information be published on the agency website. Based on interviews and discussion with administrative staff, it was determined that the agency efforts toward the collection, storage, and publication of sexual abuse data are in the beginning stages. The requirements for storage, publication and destruction of the data cannot be implemented until the initial requirements regarding the collection of the data have been met.

Policy, Matrials, Interviews, and other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 22, Sexual Abuse and Assault and PREA, p.12.
(2) Auditor Notes-Discussion with Byron Jasis, Assistant Director, Keeton Corrections-Paducah.
(3) Auditor Notes-Interview with Karen Hall, Vice President/Operations.

Corrective Action Required:

(1) Amend the PREA policy at p.12 and add poilicy provisions regarding the storage, retention, and publication of information regarding sexual abuse allegations to conform with the requirements of this standard as stated above.
(2) Train staff on the policy revisions and document the training.

(1) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Amend the PREA policy at p.12 and add poilicy provisions regarding the storage, retention, and publication of information regarding sexual abuse allegations to conform with the requirements of this standard as stated above.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:

On August 26, 2016 the auditor reviewed Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and As sault and

PREA. Language was added to the policy addressing the storage, retention, and publication of information regarding sexual abuse allegations occurring within the agency. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Keeton Corrections Policy and Procedure 23.1 (formerly Policy 22) Sexual Abuse and Assault and PREA (revised) at pp. 12-13.

(2) Plan of Corrective Action/Deliverables:
(A) Assigned Staff-Byron Jasis and the Facility Director.
(B) Task- Train staff on the policy revisions and document the training.
(C) Anticipated Completion Date-October 27, 2016.

Verification of Corrective Action Since the Audit:
On December 1, 2016 the auditor reviewed a memorandum from Lucy May dated December 1, 2016 documenting facility staff had been trained in the revised policy. The facility is now in compliance with this corrective action item and the standard in general.

Policy, Materials, Interviews, and Other Evidence Reviewed:

(1) Memorandum from Lucy May dated October 22, 2016 documenting that facility staff had been trained in the revised policy.

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.

Joseph P. Rion — December 21, 2016

Auditor Signature — Date