Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report March 31, 2021

Auditor Information

Name: Robert Burns Latham	**Email:** RobertBLatham@icloud.com
Company Name: Latham Corrections Consulting LLC	
Mailing Address: 677 Idlewild Circle	**City, State, Zip:** Birmingham, Alabama 35205
Telephone: 205-746-1905	**Date of Facility Visit:** October 1-2, 2020

Agency Information

Name of Agency Tennessee Children's Home		**Governing Authority or Parent Agency** *(If Applicable)* Click or tap here to enter text.	
Physical Address: 804 Branham Hughes Circle		**City, State, Zip:** Spring Hill, Tennessee 37174	
Mailing Address: same as physical address		**City, State, Zip:** Click or tap here to enter text.	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency Website with PREA Information: https://www.tennesseechildrenshome.org/about-us/pathways-financials/

Agency Chief Executive Officer

Name: Brian L. King	
Email: bking@tennesseechildrenshome.org	**Telephone:** 931-486-2274 ext. 215

Agency-Wide PREA Coordinator

Name: Dana Lawson	
Email: dlawson@tennesseechildrenshome.org	**Telephone:** 931-486-2274 ext. 225
PREA Coordinator Reports to:	**Number of Compliance Managers who report to the PREA Coordinator:**

Brian L. King	3

Facility Information

Name of Facility: Tennessee Children's Home West	
Physical Address: 170 Frank Latham Road	**City, State, Zip:** Pinson, TN 38366
Mailing Address (if different from above): same as physical address	**City, State, Zip:** Click or tap here to enter text.

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

Facility Website with PREA Information: https://www.tennesseechildrenshome.org/about-us/pathways-financials/

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

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

☐ ACA

☐ NCCHC

☐ CALEA

☒ Other (please name or describe: Council on Accreditation (COA)

☐ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
Program Accountability Review conducted by TN Department of Children's Services and annual licensing reviews conducted by TN Department of Children's Services

Facility Administrator/Superintendent/Director

Name: Dr. Jeremy Northrop	
Email: jnorthrop@tennesseechildrenshome.org	**Telephone:** 731-989-7335 ext. 211

Facility PREA Compliance Manager

Name: Dr. Jeremy Northrop	
Email: jnorthrop@tennesseechildrenshome.org	**Telephone:** 731-989-7335 ext. 211

Facility Health Service Administrator ☒ N/A

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

Facility Characteristics

Designated Facility Capacity:	24
Current Population of Facility:	12
Average daily population for the past 12 months:	12
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males
Age range of population:	13-18
Average length of stay or time under supervision	63 days
Facility security levels/resident custody levels	Level 2 Congregate Care

Number of residents admitted to facility during the past 12 months	34
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	34
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	34
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No

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

Number of staff currently employed by the facility who may have contact with residents:	21
Number of staff hired by the facility during the past 12 months who may have contact with residents:	4
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	6
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	3
Number of single resident cells, rooms, or other enclosures:	24
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	0
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0

Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☐ Yes ☒ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☒ Yes ☐ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☐ Local hospital/clinic ☒ Rape Crisis Center ☐ Other (please name or describe:)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☒ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: Tennessee Department of Children's Services (DCS) ☐ N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	0
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police

	☐ A U.S. Department of Justice component ☒ Other (please name or describe: Tennessee Department of Children's Services (DCS) ☐ N/A

Audit Findings

Audit Narrative

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

Introduction

The Prison Rape Elimination Act (PREA) onsite audit of Tennessee Children's Home West (TCH West) was conducted October 1-2, 2020. The parent agency for TCH West is Tennessee Children's Home located at 804 Branham Hughes Circle, Spring Hill, TN 37174. The audit was conducted by Robert B. Latham from Birmingham, Alabama, who is a U. S. Department of Justice Certified PREA auditor for juvenile facilities. The auditor conducted the audit as a single auditor with no additional support staff. The facility contacted the auditor regarding the audit and a contract was agreed upon and signed July 24, 2019. There are no known existing conflicts of interest or barriers to completing the audit.

Tennessee Children's Home Mission Statement
Tennessee Children's Home is committed to improve the lives of those we influence through quality services in a Christian atmosphere.

Tennessee Children's Home Vision
Those served by Tennessee Children's Home will learn to live healthy physical, mental, social, and Christian lives.

Audit Methodology
Pre-Onsite Audit Phase

Prior to being onsite, the PREA Coordinator and the auditor had discussions concerning access to the facility and staff, the audit process, logistics for the onsite phase of the audit, and goals and expectations. The PREA Coordinator was very receptive to the audit process and was well informed of the role of the auditor and the expectations during each stage of the PREA audit.

Notice of Audit Posting and Timeline
The audit notice was posted March 16, 2020 and reposted September 26, 2020 due to rescheduling. The notices were in English and Spanish. The audit notice was posted using a large font and easy-to-read language. The audit notices were placed throughout the facility, in places visible to all residents and staff. Pictures of the posted audit notices were emailed to the auditor on March 16, 2020 and reposted September 26, 2020 for verification. Further verification of their placement was made through observations during the onsite review. The audit notices included a statement regarding confidentiality of resident and staff correspondence with the auditor. No correspondence was received during any phase of the audit.

Pre-Audit Questionnaire (PAQ) and Supporting Documentation
The PAQ and supporting documentation was received February 5, 2020. The PAQ was completed on February 5, 2020. The documentation was received on a flash drive. The documentation was well organized by standard. The auditor reviewed the PAQ, policy, procedures, and supporting documentation. Using the Auditor Compliance Tool and Checklist of Documentation, the auditor formed an issues log and further discussed the documentation with the PREA Coordinator during the week.

Requests of Facility Lists

TCH West provided the following information for interview selections and document sampling:

Complete Resident Roster	An up-to-date roster was provided upon arrival to the facility.
Youthful inmates/detainees	N/A (TCH West does not accept youthful inmates/detainees.)
Residents with physical disabilities	None were identified.
Residents with cognitive disabilities	None were identified.
Residents who are Limited English Proficient	None were identified.
Lesbian, Gay, and Bisexual Residents	None were identified.
Transgender or Intersex Residents	None were identified.
Residents in segregated housing	N/A (TCH West does not have segregated housing.)
Residents in isolation	None were identified or observed.
Residents who reported sexual abuse	None were identified.
Residents who reported sexual victimization during risk screening	None were identified.
Complete Staff Roster	The staff roster and schedule were provided upon arrival to the facility.
Specialized Staff	Specialized staff were identified on the roster.
All contractors who have contact with the residents	The facility identified no contractors who have contact with the residents.
All volunteers who have contact with the residents	The facility has no volunteers.
All grievances/allegations made in the 12 months preceding the audit	Zero (0) grievances concerning allegations of sexual abuse and sexual harassment
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	One (1) allegation of sexual harassment
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	One (1) allegation of sexual harassment
Incident Reports	One (1) incident reports regarding sexual harassment
All hotline calls made in the 12 months preceding the audit	Zero (0); All allegations of sexual abuse or sexual harassment are reported through the DCS hotline.

External Contacts
The following external contacts were made:

Just Detention International	Just Detention International reviewed their database for records and information and reported no information for the preceding 12 months.
Community Based Organizations (CBOs)	WRAP (Wo/Men's Resource and Rape Assistance Program)
The Tennessee Department of Children Services Hotline	The auditor contacted the Tennessee Department of Children Services Hotline at 877-237-0004.
SAFE/SANE Programs	SANEs are available through Jackson-Madison County General Hospital.

Research

Tennessee Mandated Reporter Law - Statutory citation(s): T.C.A. §§ 37-1-401, 37-1-403, 37-1-410, 37-1-412, 37-1-413, 37-1-602, 37-1-605, 40-35-111.

- Who is required to report sexual abuse?
  Any person, including, but not limited to, any: Physician, osteopathic physician, medical examiner, chiropractor, nurse or hospital personnel engaged in the admission, examination, care or treatment of persons; Any other health or mental health professional; Practitioner who relies solely on spiritual means for healing; School teacher or other school official or personnel; Judge of any court of the state; Social worker, day care center worker, or other professional child care, foster care, residential or institutional worker; Law enforcement officer; Authority figure at a community facility, including any facility used for recreation or social assemblies for educational, religious, social, health or welfare purposes, including, but not limited to, facilities operated at schools, the boy or girl scouts, the YMCA or YWCA, the boys and girls club or church or religious organizations; or

- When is a report required?
  Knowledge or reasonable cause to suspect that a child has been sexually abused, regardless of whether such person knows or believes that the child has sustained any apparent injury as a result of such abuse.

- Where does it go? The local office of the Department of Children's Services (DCS) or to the judge having juvenile jurisdiction or to the office of the sheriff or the chief law enforcement official of the municipality where the child resides. Each report of known or suspected child sexual abuse occurring in a facility licensed by the department of mental health and substance abuse services, or any hospital, shall also be made to the local law enforcement agency in the jurisdiction where such offense occurred.

- What timing and procedural requirements apply to reports?

  Reports must be made immediately. Reports may be made via telephone or otherwise, on the Department of Children's Services Central Intake Division hotline at 1-877-237-0004 (1-877-54ABUSE) or online (at: https://apps.tn.gov/carat/referral/emergency.html).

Onsite Audit Phase

Entrance briefing

An entrance briefing was held with the Facility Director and Case Manager Supervisor. The agenda for the two days was discussed, and the auditor began the audit by interviewing staff and residents. The site review was conducted on the second day of the audit.

Site review
The auditor had access to, and observed, all areas of the facility. The auditor was provided a diagram of the physical plant during the pre-onsite phase of the audit and was thus familiar with the layout of the facility. In addition to the four (4) living units, the auditor reviewed outside recreation, indoor gymnasium, staff offices, and the school. On the first day of the onsite audit the population of the facility was six (6) juveniles.

Processes and areas observed
The auditor observed the intake and risk screening to better understand the process. Grievance boxes are accessible to the residents in the school and each house. Grievance forms are available. Residents are permitted to keep pencils. The grievance boxes are checked daily.

Phones for reporting sexual abuse, sexual harassment or for contacting external crisis intervention services are available through a resident's case manager. The staff conducting the site review described the showering process, pointed out the location PREA posters with telephone numbers for reporting sexual abuse and sexual harassment. The PREA posters are prominently placed in the housing units and the administrative building. The auditor informally asked residents about reporting and basic information about sexual safety at the facility.

Specific area observations
Residents have single rooms with their own bathroom with a shower. Wherever residents were present, the auditor observed staff actively supervising the residents. The auditor observed the facility to be compliant with the 1:8 ratio requirements. Staff supervision mitigates blind spots.

Exit briefing
An exit briefing was held with the Case Manager Supervisor. The auditor discussed the onsite audit. Some additional documentation for residents interviewed was requested and provided. The documentation provided by the facility, prior to the onsite phase of the audit, did omit some required documentation. Interviews with the staff and residents demonstrated training and education were effective.

Specific areas discussed:
115.313
Additional Unannounced rounds were required to demonstrate the practice is fully implemented. Corrective action has been completed.

115.315
Staff training for how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents was required. Corrective action has been completed.

115.321
Memorandum of Understanding for Victim Advocacy Services was required. Corrective action is complete.

115.322

The agency shall publish the investigations policy for allegations of sexual abuse and sexual harassment on its website. Corrective action is complete.

115.335
Specialized training for medical and mental health care staff was required. Corrective action has been completed.

115.354
The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Corrective action has been completed.

115.389
Annual Report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.
(c) The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.
(d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted.
Corrective action has been completed.

Interviews Logistics

Location and Privacy
Interviews were held in a conference room. The location provided privacy, was centrally located to minimize disruption of daily activities and programing, and provided room for social distancing and air circulation needed for coronavirus precautions.

Selection Process
Specialized staff were selected based on their respective duties in the facility. Nine (9) staff were interviewed using the random staff interview protocol. There were nine (9) staff present during the two days of the audit. Six (6) residents were interviewed using the random resident interview questionnaire. The resident population was six (6) on the first day of the audit. There were no target interviews identified.

Interview Protocols	Number of Interviews
Administration and Agency Leadership	
Agency Head (President)	1
Facility Director	1
PREA Coordinator	1
PREA Compliance Manager	1
Medical Staff	N/A
Mental Health Staff	1
Non-Medical Staff Involved in Cross-Gender Strip Searches or Visual Body Cavity Searches	N/A
Administrative (Human Resources) Staff	1
Agency Contract Administrator	N/A
Intermediate or Higher-level Facility Staff (unannounced rounds)	1

SAFE and SANE	1
Investigative Staff	1 (DCS Investigator)
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff who Supervise Residents in Isolation (no isolation)	N/A
Staff on the Incident Review Team	1
Designated Staff Member Charged with Monitoring Retaliation	1
Security First Responders	N/A
Non-Security Staff First Responders	1
Intake Staff	1
Random Sample of Staff	
Total Random Sample of Staff	9 (all staff present)
Volunteers Contractors who have Contact with Residents	
Volunteers	N/A
Contractors	N/A
Residents	
Random Sample of Residents from all Housing Units	6
Targeted Residents	
Residents who Reported a Sexual Abuse	None identified
Residents with Cognitive Disabilities	None identified
Residents with Physical Disabilities	None identified
Limited English Proficient Residents	None identified
Gay, Lesbian, and Bisexual Residents	None identified
Transgendered and Intersex Residents	None identified
Residents in Isolation	None identified
Residents who Disclosed Prior Sexual Victimization During Risk Screening	None identified
Interview Totals	
Total Number of Staff Interviews	23
Total Number of Resident Interviews	6
Total Number of Interviews	29

Interviewed Residents Length of Time at Facility

Days or Months	Number of Residents
1 Day to 31 Days	1
32 Days to 6 Months	5
7 Months to 12 Months	0
13 Months Plus	0
Total	6

Records Review

Name of Record	Total Records Reviewed
Personnel Records/Documentation	26
Volunteers and Contractors Files/Documentation	0
Training Files/Documentation/Records	15
Resident Records	15
Medical/Mental Health Records and Documentation for Victims	0
Grievance Forms (Sexual Abuse and Sexual Harassment)	0

All Incident Reports (Sexual Abuse and Sexual Harassment)	1
Investigation Records (Sexual Abuse and Sexual Harassment)	1

Investigative Files

Youth-on-Youth Sexual Victimization	Substantiated	Unsubstantiated	Unfounded
Nonconsensual Sexual Acts	0	0	0
Abusive Sexual Contact	0	0	0
Sexual Harassment	0	1	0
Staff-on-Youth Sexual Abuse	0	0	0
Staff Sexual Misconduct	0	0	0
Staff Sexual Harassment	0	0	0

Reporting Method	**Sexual Abuse**		**Sexual Harassment**	
	Youth-on-Youth	Staff-on-Youth	Youth-on-Youth	Staff-on-Youth
Hotline	0	0	0	0
Grievance	0	0	0	0
Verbal Report	0	0	1	0
Anonymous	0	0	0	0
Third Party	0	0	0	0
Reports by Staff	0	0	0	0

Facility Characteristics

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

Characteristics Related to PREA and Sexual Safety

Introduction	
Parent Agency	Tennessee Children's Home
Other Significant Relationship Information	Contracted with the Tennessee Department of Children's Services
Facility Name	Tennessee Children's Home West
Facility Address	170 Frank Latham Road, Pinson, TN 38366
Age of Facility	1995
Total Facility Rated Capacity	24
Resident Population Size and Makeup	
Average daily population in the last 12 months	12
Actual population on day 1 of the onsite portion of the audit	6
Population Gender	Male
Population Ethnicity	Multiethnic

Average Length of Stay	63 days
Staff Size and Makeup	
Total Staff Size	25
Number of Security Staff	0
Types of Supervision Practiced:	Direct Supervision
Number of Volunteers who may have contact with residents	0
Number of Contractors who may have contact with residents	0
Number of Interns who may have contact with residents	0
Number and Type of Housing Units	
Number of single-occupancy cells	24
Number of multiple-occupancy cells	0
Number of open-bay dorms	0
Number of segregation/isolation units	0
Number of medical units	0
Number of closed units	0
Type of Supervision (direct or indirect)	Direct
Video Monitoring	No

Facility Operations

Physical Plant Description

Tennessee Children's Home began in 1909 as the Tennessee Orphan Home in Columbia, Tennessee. It was created to meet the needs of the three Scotten children, who had been tragically orphaned. In 1935, the Home purchased the campus of the Branham and Hughes Military Academy and moved to Spring Hill, Tennessee. As with many of the old orphanages, the Home was designed as an institutional facility with central dining, central laundry, dormitory living, and a small farming operation. The approach to childcare was to provide the basic physical needs of children and to offer Christian instruction. The number of children served grew dramatically throughout the decades, and in late 1982, the name was changed to Tennessee Children's Home. The institutional approach was replaced with family oriented group homes. Dormitories were remodeled into single-family homes, with a maximum of eight children in each home. Central dining was replaced with family meals in the group homes. The family groups now individually carry on most activities, such as home devotionals, church attendance, housekeeping, laundry, cooking, and cleanup. In 1988, THC expanded again by merging with West Tennessee Children's Home, followed in 2000 and 2001 by mergers with Happy Hills Youth Ranch near Ashland City, and West Tennessee Christian Services in Knoxville. Since 1909, TCH has cared for over 20,000 children. Their professional services coupled with loving staff and a Christian environment make Tennessee Children's Home one of the finest programs in the state.

TCH East has been in operation for decades. There has always been a significant relationship between Tennessee Children's Home and area churches. These relationships have made it possible to build and maintain the campus, having occupied it as Tennessee Children's Home for about 25 years.

TCH West is situated on 250 acres. There are six (6) buildings on campus. There are four (4) residential housing units. Each house provides living space for eight (8) residents and two (2) house parents. At any time only three (3) housing units are open housing 24 residents. House parents work two weeks on and then have a week off. Residents are moved to another housing unit when the house

parents are off for a week. During the on-site audit one house was being renovated. During sleeping hours from 9:00 p.m. to 6:00 a.m. the residents are supervised by an awake night staff located in each housing unit. The night staff conduct rounds that are recorded on a log. The housing units or any other parts of the campus do not use video monitoring as part of supervision. TCH West relies on staff coverage for supervising residents. The facility has a school, gymnasium, and administrative offices.

Services Available
Residential
As the flagship program at Tennessee Children's Home, the residential care encompasses almost all of the services TCH provides. They provide for physical, social, emotional, spiritual, and educational needs of the children and youth in a safe and secure environment. Children may be placed in their care through the state or through personal placements. The children live in on-site homes in family situations with other children, and with house parents/residential counselors. These residential counselors are the primary care givers and are assisted by the case workers and other staff. The residential program at Tennessee Children's Home is highly structured to help the children be successful, and includes:

- Daily chores
- On-site school (including Bible classes)
- Tutoring services
- Church attendance
- Counseling services (for both children and families)
- Substance abuse counseling

On weekends, the parents may visit their children or children may go home; recreational activities are provided for those remaining on campus. In its entirety, the residential care program helps the children entrusted to us develop life skills, self-discipline, and a greater understanding of their worth as children of God.

Education
Tennessee Children's Home offers on-site instruction by certified teachers for residential placements through the Cornerstone School (SH), Duncan Academy (ET), and New Heights Schools (WT). Experience has shown that teachers dedicated and focused on ensuring the children's academic success are crucial in developing healthy self-esteem. Because of this, educational services have become foundational in programming.

TCH schools offer special education, as well as tutoring, and mitigate any truancy issues by being located on campus. They are committed to maintaining a student-teacher ratio of one teacher to every eight students. This specialized attention, coupled with on-site tutoring and accountability, has allowed children that are two and three years behind in school to regularly return to grade level work within just six months.

Substance Abuse Education
Tennessee Children's Home is a level II facility that provides care for teenage boys with moderate clinical needs who are unable to live at home or in a foster home, and who require temporary care in a group or residential setting. The treatment consists of residential behavioral intervention using the EQIUP model to provide a highly structured home and school environment. Individual and Family counseling, family involvement and residential counseling helps to support both our youth and their families struggling with behavioral issues and substance abuse.

The program has weekly substance abuse group education that follows the nationally recognized curriculum: Hazelton Living in Balance program. This curriculum covers the following: assessment of mental and physical needs, treatment planning, individual assignments, education about substance use disorders, life skills training, maintaining sobriety, relapse prevention training, individual and family therapy and finally advocating of continued support from a twelve-step group or support from their family and friends.

TCH offers aftercare services that help our youth to transition back into their home and community and ensure a successful reunification.

Counseling
The Therapist's at the Tennessee Children's home offer family, individual and group counseling to all the residents and their families. The services offer a safe space for families and adolescents to work on communication and relationship building.

The therapists employ many modalities when it comes to working with clients in therapy including: CBT, experiential, solution focused and EMDR. TCH believe it is never too late to build a stronger family. They love to walk alongside clients as they gain the insight to make small and large life adjustments. These insights lead to reduced stress and a better overall well-being.

Spiritual Guidance
The caring staff encourage children's spiritual growth and awareness through personal examples, daily devotions, prayers at meals and encouragement of regular church attendance.

Summary of Audit Findings

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

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

Standards Exceeded

Number of Standards Exceeded: 2
List of Standards Exceeded:
Standard 115.317 Hiring and promotion decisions
Standard 115.331 Employee Training

Standards Met

Number of Standards Met: 41
List of Standards Met:

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met:

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

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

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. TCH Organizational Chart
4. TCH West Organizational Chart
5. TCH West Pre-Audit Questionnaire

Interviews:

1. Interview with the PREA Coordinator
2. Interview with the PREA Compliance Manager

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):

115.311 (a)
PAQ: The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility has a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

TCH policy states a commitment to a zero-tolerance standard for all forms of sexual abuse, sexual harassment, assault, misconduct, and rape through private provider implementation of PREA as outlined in Public Law 108-79, Section 3.

The policy outlines how the facility will implement the zero-tolerance approach to preventing, detecting, and responding to sexual abuse, sexual assault, sexual misconduct, sexual harassment, or rape. Definitions of prohibited behaviors are included in the policy. The resident handbook includes disciplinary sanctions for sexual misconduct.

The policy is inclusive of strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

115.311 (b)
PAQ: The agency employs or designates an upper-level, agency-wide PREA Coordinator. The PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards at the facility. The position of the PREA Coordinator is in the agency's organizational structure.

The TCH HR/PQI Manager serves as the PREA Coordinator. The PREA Coordinator is identified on the agency's organizational chart. The PREA Coordinator confirmed she has sufficient time and authority to develop, implement and oversee agency efforts to comply with the PREA standards.

115.311 (c)
PAQ: The facility has designated a PREA Compliance Manager. The PREA Compliance Manager has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. The position of the PREA Compliance Manager in the agency's organizational structure.

Each facility designates a PREA Compliance Manager. The PREA Compliance Manager for the facility is the Facility Director. The PREA Compliance Manager confirmed he has sufficient time and authority to coordinate facility efforts to comply with the PREA Juvenile Standards.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor confirmed the agency and facility is fully compliant with this standard regarding zero tolerance of sexual abuse and sexual harassment and designation of an agency wide PREA Coordinator. No corrective action is required.

Standard 115.312: Contracting with other entities for the confinement of residents

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

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. TCH West Pre-Audit Questionnaire responses
4. Tennessee Department of Children's Services (DCS) Contract

Findings (By Provision):

115.312 (a)

The Tennessee Department of Children's Services (DCS) contracts for the confinement of its residents with TCH West. The contract specifies TCH's obligation to adopt and comply with the PREA standards. The auditor reviewed the contract for verification.

115.312 (b)

The contract provides for DCS contract monitoring to ensure TCH West is complying with the PREA standards. The auditor reviewed the contract for verification.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor confirmed the agency and facility is fully compliant with this standard regarding contracting with other entities for the confinement of residents. No corrective action is required.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

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

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

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

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

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. TCH Youth Supervision Policy
3. DCS Policy 18.8 Zero - Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 27.38 - Youth Supervision
5. Staffing Plan
6. 2020 Staffing Plan Assessment
7. Unannounced Supervisory Rounds
8. TCH West Pre-Audit Questionnaire responses

Documents (Corrective Action):

1. Unannounced Supervisory Rounds

Interviews:

1. Interview with the Facility Director
2. Interview with the PREA Coordinator
3. Interview with the PREA Compliance Manager
4. Interview with Intermediate or Higher-Level Facility Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.313 (a)
PAQ: Since the 2017 PREA audit:

1. The average daily number of residents: 10
2. The average daily number of residents on which the staffing plan was predicated: 10

Policy states each agency develops, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, agency will take into consideration:

a) Generally accepted juvenile detention and correctional/secure residential practices;
b) Any judicial finding of inadequacies;
c) Any findings of inadequacy from federal investigative agencies;
d) Andy finding of inadequacy from internal or extern oversight bodies;
e) All components of the facilities physical plant (including “blind spots” or areas where staff or residents may be isolated);
f) The composition of the resident population;
g) The number and placement of supervisory staff;
h) Institution programs occurring on a particular shift;
i) Any applicable State or local laws, regulations, or standards;
j) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
k) Any other relevant factors.

The Facility Director and PREA Compliance Manager confirmed the facility regularly develops a staffing plan, maintains adequate staffing levels to protect residents against sexual abuse, considers video monitoring as part of the plan, and documents the plan. When assessing staffing levels and the need for video monitoring, the staffing plan considers: generally accepted juvenile detention and correctional/secure residential practices; any judicial findings of inadequacy; any findings of inadequacy from Federal investigative agencies; any findings of inadequacy from internal or external oversight bodies; all components of the facility’s physical plant (including “blind spots” or areas where staff or residents may be isolated); the composition of the resident population; the number and placement of supervisory staff; institution programs occurring on a particular shift; any applicable State or local laws, regulations, or standards; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. The Facility Director stated he checks for compliance with the staffing plan through internal audit.

115.313 (b)
PAQ: Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan.

Policy states the agency complies with the staffing plan except during limited and discrete exigent circumstances, and fully documents deviations from the plan during such circumstances.

The Facility Director confirmed there have been no circumstances in which the facility has been unable to meet the requirements of the staffing plan. The facility documents all instances of non-compliance with the staffing plan and includes an explanation for non-compliance.

115.313 (c)
PAQ:

1. The facility is obligated by law, regulation, or judicial consent decree to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours.
2. The facility maintains staff ratios of a minimum of 1:8 during resident waking hours.
3. The facility maintains staff ratios of a minimum of 1:16 during resident sleeping hours.
4. In the past 12 months:
5. The number of times the facility deviated from the staffing ratios of 1:8 security staff during resident waking hours: Zero (0)
6. The number of times the facility deviated from the staffing ratios of 1:16 security staff during resident sleeping hours: Zero (0)

TCH has developed and implemented a staffing plan that maintains adequate staffing levels and ratios of 1:5 during waking hours and 1:8 during sleeping hours to protect residents against sexual abuse. Deviations would be documented. During the twelve-month audit period, there were no deviations from the staffing plan. Staff call-ins ensure required staffing levels

The Facility Director confirmed TCH is obligated by DCS to maintain ratios of staff-to-youth ratios of 1:5 during the day and 1:8 at night. He ensures the facility maintains appropriate staffing ratios through holdovers and call-ins. The house parents cannot leave the campus without approval.

115.313 (d)
PAQ: At least once every year the agency or facility, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to:

1. The staffing plan;
2. Prevailing staffing patterns;
3. The deployment of monitoring technology; or
4. The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

Policy states whenever necessary, but no less frequently than once each year, for each agency, in consultation with the PREA Coordinator assess, determines, and documents whether adjustments are needed to:

a) The staffing plan;
b) Prevailing staffing patterns;
c) The agency's deployment or updating of video monitoring systems and other monitoring technologies the agency considers how such technology may enhance the agency's ability to protect residents from sexual abuse; and
d) The resources the agency has available to commit to ensure adherence to the staffing plan.

The PREA Coordinator confirmed being consulted regarding any assessments of, or adjustments to, the staffing plan. She confirmed the assessment occurs annually and is documented through the Staffing Plan Assessment. The auditor reviewed the 2020 Staffing Plan Assessment for verification.

115.313 (e)
PAQ: The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The facility documents unannounced rounds. The unannounced rounds cover all shifts. The facility prohibits staff from alerting other staff of the conduct of such rounds.

Policy states each secure agency develops written local search procedures of intermediate-level or higher-level supervisors to conduct and document unannounced search rounds to identify and deter staff sexual abuse and sexual harassment. Written local search procedures are implemented for both day and night shifts.

The Facility Director confirmed the PAQ responses. He stated the unannounced rounds are documented in logbooks. He prevents staff from alerting other staff that he is conducting the unannounced rounds by not announcing they are occurring.

The unannounced rounds were not conducted during a period of time after a change in administration. This standard provision will require corrective action to show the process is in place and institutionalized.

PREA Site Review: During the onsite tour of the facility the auditor observed the classrooms and homes were compliant with the staffing ratios. Staff were actively supervising and engaging with the residents.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is not fully compliant with this standard regarding supervision and monitoring. Corrective action has been completed.

115.313 (e)
The unannounced rounds were not conducted during a period of time after a change in administration. This standard provision will require corrective action to show the process is in place and institutionalized. The facility conducted unannounced rounds and emailed them to the auditor for verification.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

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

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

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

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

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

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

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

115.315 (f)

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

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. TCH Viewing and Searches Policy
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Coordinator
2. Interviews with a Random Sample of Staff
3. Interviews with a Random Sample of Residents
4. Interviews with Transgendered and Intersex Residents – N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):

115.315 (a)
PAQ: The facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents.
In the past 12 months:

1. The number of cross-gender strip or cross-gender visual body cavity searches of residents: Zero (0)
2. The number of cross-gender strip or cross-gender visual body cavity searches of residents that did not involve exigent circumstances or were performed by non-medical staff: Zero (0)

TCH does not conduct cross-gender strip searches or cross-gender visual body cavity searches.

115.315 (b)
PAQ: The facility does not permit cross-gender pat-down searches of residents, absent exigent circumstances.
In the past 12 months:

1. The number of cross-gender pat-down searches of residents: Zero (0)
2. The number of cross-gender pat-down searches of residents that did not involve exigent circumstance(s): Zero (0)

TCH policy does not allow any types of cross-gender searches including pat down searches.

Policy review and interviews with staff and residents confirmed cross-gender searches are restricted.

115.315 (c)
PAQ: Facility policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified.

TCH policy requires all searched are documented in a narrative format stating the reasonable cause and assessed risk of harm to self or others which triggers any search.

115.315 (d)
PAQ:
1. The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera).
2. Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing.

Facility policies and procedures enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their buttocks or genitalia. Facility policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit. Residents shower in bathrooms with one shower behind a closed door. Female staff knock and announce their presence when entering the sleeping and bathroom area.

Resident interviews confirmed female staff announce their presence before entering residents' rooms and residents are never naked in full view of female staff. Each resident has his own bathroom with a shower.

Staff interviews confirmed female staff announce their presence before entering residents' rooms. Staff confirmed residents are able to dress, shower, and use the toilet without being viewed by staff of the opposite gender.

PREA Site Review: Staff conducting the tour described the shower process. Each resident has his own bathroom with a shower.

115.315 (e)
PAQ: The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident’s genital status. Zero (0) such searches occurred in the past 12 months.

Policy states transgender or intersex youth will not be searched or physically examined for the sole purpose of determining genital status. If the child/youth’s genital status is unknown, this information

may be determined through an interview, review of medical records or as part of the child/youth's medical check-up with a medical practitioner.

Staff interviewed confirmed they are aware policy prohibits them from searching or physically examining a transgender or intersex resident for the purpose of determining the resident's genital status.

115.315 (f)
Policy states all staff members shall participate in training on conducting searches of trans gender and intersex residents in a professional and respectful manner, consistent with security needs.

Staff interviewed confirmed they had not received such training.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is not fully compliant with this standard regarding limits to cross-gender viewing and searches. Corrective action has been completed.

115.315 (f)
Staff were trained how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents. Staff training logs were provided for verification the training has been received.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

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

115.316 (a)

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

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

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

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

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

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

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

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

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

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

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

115.316 (b)

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

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

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of

first-response duties under §115.364, or the investigation of the resident's allegations?
☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. TCH Limited English Proficiency (LEP) Guidelines
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. AVAZA Language Services Corporation
5. Tennessee Foreign Language institute
6. Special Education Certification
7. Title VI of the 1964 Civil Rights Act Implementation Plan
8. PREA Posters with Hotline Numbers for Outside Support Services (English and Spanish)
9. End Silence Brochure: Youth Speaking Up about Sexual Abuse in Custody (English and Spanish)
10. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Agency Head (President)
2. Interview with the PREA Coordinator
3. Interviews with Residents with Disabilities and Limited English Proficient Residents - N/A
4. Interviews with a Random Sample of Staff

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):

115.316 (a)

PAQ: The agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

TCH ensures residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. However, the facility does not accept juveniles with an IQ lower than 70.

Policy states appropriate provisions are made as necessary for children/youth who are limited English proficient, have disabilities (including those who are deaf or hard of hearing, those who are blind or have low vision), and those with low intellectual, psychiatric, or speech disabilities.

The President confirmed the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. There were no residents (with disabilities or who are limited English proficient) who were identified during the onsite audit.

115.316 (b)

PAQ: The agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

The agency ensures meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient. The facility has interpreter services provided by AVAZA Language Services Corporation and the Tennessee Foreign Language Institute. Hotline numbers, PREA brochures and PREA posters are available in Spanish and English.

There were no residents identified as limited English proficient during the onsite audit.

115.316 (c)

PAQ: Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations.

1. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used.
2. In the past 12 months, the number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations: Zero (0)

Policy states TCH will not rely on resident interpreters except in urgent circumstances where safety may be compromised.

Staff interviewed confirmed the agency does not use resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. Staff did not have knowledge of resident interpreters, resident readers, or other types of resident assistants being used in relation to

allegations of sexual abuse or sexual harassment. There were no residents (with disabilities or who are limited English proficient) who were identified during the onsite audit.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding residents with disabilities and residents who are limited English proficient. No corrective action is required.

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

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

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

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

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

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

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

115.317 (b)

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

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

115.317 (c)

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

- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

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

115.317 (d)

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

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

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

115.317 (f)

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

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

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

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. TCH Employee Background Checks Policy
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. Employee Acknowledgement and Notification of PREA
5. CS-0687, Background Check History and IV-E Eligibility Checklist
6. Tennessee Department of Children's Services Database Search Results
7. Acknowledgment Form
8. TCH Employee Application
9. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with Human Resources Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.317 (a)
PAQ: Agency policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who:

1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
3. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

The facility does not hire or promote anyone who may have contact with residents, and does not enlist the services of any contractor who may have contact with residents, who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse.

These questions are asked during the hiring process, for promotions and during annual evaluations. The auditor reviewed applications and employee questionnaires for verification.

115.317 (b)
PAQ: Agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

The TCH Human Resources Director confirmed the agency considers prior incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

115.317 (c)
PAQ: Agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, (b) consults any child abuse registry maintained by the State or locality in which the employee would work; and (c) consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse

During the past 12 months:

1. The number of persons hired who may have contact with residents who have had criminal background record checks: 4
2. The percent of persons hired who may have contact with residents who have had criminal background record checks: 100%

Before hiring new employees, who may have contact with residents, the facility performs an extensive criminal background records check including: the National Sex Abuse Registry, Vulnerable Persons Abuse Registry, Tennessee Felony Database Clearance, Drug Offence Registry, and the Tennessee Department of Children's Services Database. They contact prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Initial and annual criminal background checks are reported on the Background Check History and IV-E Eligibility Checklist form.

The TCH Human Resources Director confirmed the facility performs criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. The facility also consults the Tennessee Department of Children's Services Database.

The auditor reviewed Employee Background Checks and Tennessee Department of Children's Services Database Search Results for verification.

115.317 (d)
PAQ: Agency policy requires that a criminal background records check be completed, and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents.

During the past 12 months:

1. The number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 0
2. The percent of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: N/A

A criminal background records check is completed, and the Tennessee Department of Children's Services Database is consulted before enlisting the services of any contractor who may have contact with residents.

The TCH Human Resources Director confirmed the facility performs criminal record background checks and considers pertinent civil or administrative adjudications before enlisting the services of any contractor who may have contact with residents. The facility also consults the Tennessee Department of Children's Services Database.

The facility does not use contractors.

115.317 (e)
PAQ: Agency policy requires that either criminal background records checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

TCH policy requires criminal records background check of current employees and contractors are conducted annually.

The auditor reviewed criminal background record checks of current employees for verification. The facility does not use contractors.

115.317 (f)
TCH asks all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

The TCH Human Resources Director confirmed TCH asks all applicants and employees who may have contact with residents about previous misconduct described in section (a)* in written applications for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. TCH also imposes upon employees a continuing affirmative duty to disclose any such previous misconduct.

These questions are asked during the hiring process, for promotions and during annual evaluations. The auditor reviewed applications and employment questionnaires for verification.

115.317 (g)
PAQ: Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

115.317 (h)
The TCH Human Resources Director confirmed TCH shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility exceeds this standard regarding hiring and promotion decisions. New employees and contractors receive an extensive criminal records background check upon hire and annually thereafter. No corrective action is required.

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:
1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. Facility Schematic
3. TCH West Pre-Audit Questionnaire responses

Interview:
1. Interview with the Agency Head (President)
2. Interview with the Facility Director

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):

115.318 (a)
PAQ: The agency or facility has acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012.

Policy states when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency considers the effect of the design, acquisition, expansion, or modification upon the agency's staff.

The facility is completing a renovation project to make all rooms single with individual bathrooms. One house is currently under renovation. The renovations will provide extra safety and security for the residents.

The President and Facility Director both confirmed the facility considers the ability to protect residents from sexual abuse when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities. Also, the agency would consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse.

PREA Site Review:
The auditor observed the last of four homes was being modified to single rooms with individual bathrooms.

115.318 (b)
PAQ: The agency or facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012.

The President and Facility Director both confirmed when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

PREA Site Review:
The auditor observed the facility does not have a video monitoring system.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding upgrades to facilities and technology. No corrective action is required.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

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

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

115.321 (c)

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

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

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

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

115.321 (d)

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

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

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

115.321 (e)

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

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. TCH Reporting Abuse/Neglect Policy
3. DCS Policy 14.25 Special Child Protective Services Investigations
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. Memorandum of Understanding with WRAP (Wo/Men's Resource and Rape Assistance Program) has a PREA Program'
6. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Compliance Manager
2. Interviews with a Random Sample of Staff
3. Interviews with Residents who Reported a Sexual Abuse – N/A
4. SAFE's/SANE's

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.321 (a)
PAQ: TCH is not responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct).

DCS is responsible for conducting administrative sexual abuse investigations. DCS investigators work directly with local law enforcement for criminal sexual abuse investigations.

Staff interviewed confirmed they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. They acknowledged DCS/CPS and local law enforcement are responsible for conducting sexual abuse investigations.

115.321 (b)
TCH is not responsible for conducting any form of criminal or administrative sexual abuse investigations.

115.321 (c)
PAQ: The facility offers all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim.

Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations.
During the past 12 months:

1. The number of forensic medical exams conducted: Zero (0)
2. The number of exams performed by SANEs/SAFEs: Zero (0)
3. The number of exams performed by a qualified medical practitioner: Zero (0)

The Jackson-Madison County General Hospital has SANEs available to conduct forensic medical examinations.

115.321 (d)
PAQ: TCH makes a victim advocate from a rape crisis center available to the victim, in person or by other means.

The facility has a Memorandum of Understanding for victim advocate services with WRAP (Wo/Men's Resource and Rape Assistance Program). WRAP (Wo/Men's Resource and Rape Assistance Program) has a PREA Program.

Their website states, “Victims of sexual abuse in confinement deserve advocacy and treatment services comparable to those available to victims outside of confinement. Several Prison Rape Elimination Act (PREA) standards set requirements for the level of victim services that correctional agencies are responsible for providing or coordinating, including:

- Access to victim advocates for forensic medical exams and outside confidential support services;
- Coordinated response planning; and
- Emergency medical services and ongoing mental health care for victims.

Establishing partnerships with community-based service providers is the optimal way to meet these requirements and ensure that victims’ needs are met.”

The auditor reviewed the MOU with WRAP and contacted the center to confirm victim advocates would be available.

There were no residents who reported a sexual abuse present during the onsite audit.

115.321 (e)
PAQ: If requested by the victim, a victim advocate, or qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

A victim advocate from WRAP would accompany and support a victim.

There were no residents who reported a sexual abuse present during the onsite audit.

115.321 (f)
PAQ: TCH is not responsible for administrative or criminal investigating allegations of sexual abuse and relies on another agency to conduct these investigations. DCS policy outlines they are the responsible agency, and they follow the requirements of paragraphs §115.321 (a) through (e) of the standards.

The auditor reviewed DCS Policy 14.25 Special Child Protective Services Investigations for verification.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding evidence protocol and forensic medical examinations. No corrective action is required.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

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

115.322 (b)

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

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

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

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 14.25 Special Child Protective Services Investigations
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. TCH West Pre-Audit Questionnaire responses

Document (Corrective Action):

1. Policy published at: https://www.tennesseechildrenshome.org/about-us/pathways-financials/

Interview:
Interview with the Agency Head (President)

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.322 (a)
PAQ: TCH ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.
In the past 12 months:

1. The number of allegations of sexual abuse and sexual harassment that were received: One (1)
2. The number of allegations resulting in an administrative investigation: One (1)
3. The number of allegations referred for criminal investigation: One (1)
4. Referring to allegations received in the past 12 months, all administrative and/or criminal investigations were completed: N/A

DCS policy ensures that an administrative or criminal investigation is competed for all allegations of sexual abuse, sexual assault, sexual misconduct, and sexual harassment. All incidents are

documented on the Tennessee Family and Child Tracking System (TFACTS). The TCH President stated TCH ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. He stated DCS is responsible for all investigations and local law enforcement is involved for criminal investigations.

115.322 (b)
PAQ: TCH has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is not published on the agency website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA) is not published on the facility's website. The policy requires that all allegations of sexual abuse or sexual harassment be referred for investigation to DCS. All incidents are documented on the Tennessee Family and Child Tracking System (TFACTS). The policy is published on the agency's website at: https://www.tennesseechildrenshome.org/about-us/pathways-financials/.

115.322 (c)
TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA) describes the responsibilities of both TCH and DCS.

The auditor reviewed the policy and verified the policy describes investigative responsibilities of both the agency and DCS.

115.322 (d)
Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The Tennessee Department of Children's Services (DCS) has policy governing the conduct of sexual abuse and sexual harassment investigations. The auditor reviewed DCS Policy 14.25 Special Child Protective Services Investigations and DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA for verification.

115.322 (e)
Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

There is no Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding policies to ensure referrals of allegations for investigations. Corrective action has been completed

115.322 (b)
The agency published the investigations policy for allegations of sexual abuse and sexual harassment on its website at: https://www.tennesseechildrenshome.org/about-us/pathways-financials/.

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

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

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

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

- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No
- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. TCH Staff Development Plan
4. PREA Employee Training Curriculum
5. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
6. TCH Employee Training Records
7. TCH West Pre-Audit Questionnaire responses

Interview:

1. Interviews with a Random Sample of Staff

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.331 (a)
PAQ: TCH trains all employees who may have contact with residents on the eleven (11) required topics.

Policy states all applicable agency employees are trained on:
(1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' right to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities; (6) The common reactions of juvenile victims of sexual abuse and sexual harassment; (7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and (11) Relevant laws regarding the applicable age of consent.

Staff interviewed confirmed they have received training on the eleven (11) PREA topics in standard 115.331 when hired. The auditor reviewed staff training records for verification.

115.331 (b)
PAQ: Training is tailored to the unique needs and attributes and gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training.

Policy states training is tailored to the unique needs and attributes of the residents of juvenile facilities and to the gender of the residents of the facility.

The auditor reviewed staff training records for verification.

115.331 (c)

PAQ: The number of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 21
The percent of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 100%

Policy states all agency employees receive training during orientation or in-service and through annual refresher training thereafter.

The auditor reviewed the PREA training curriculum and staff training records for verification.

115.331 (d)
PAQ: The agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

Policy states all agency employees, volunteers and contractors are required to sign form CS-0940, Employee Acknowledgement and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have read the DCS zero-tolerance policy and understand the training they have received. TCH will maintain documentation on all employees, volunteers and contractors who receive training on PREA.

The auditor reviewed employee acknowledgement forms and staff training records for verification.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility exceeds this standard regarding employee training. Employees are trained annually. No corrective action is required.

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

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

115.332 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
4. Volunteer Manual
5. Volunteer Application
6. TCH West Pre-Audit Questionnaire responses

Interviews:
Interviews with Volunteers who have Contact with Residents - N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.332 (a)
PAQ: All volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response.

1. The number of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 0

2. The percent of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: N/A

All TCH volunteers and contractors would receive training on their responsibilities under the facility's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. Currently, TCH West does not use the services of volunteers and contractors who have contact with residents.

The auditor reviewed the volunteer application and volunteer/contractor acknowledgement form for verification.

115.332 (b)
PAQ: The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

Training would be based on the services volunteers and contractors provide and the level of contact they have with residents. The facility maintains form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA) confirming that volunteers and contractors understand the training they have received.

115.332 (c)
PAQ: The agency maintains documentation confirming that volunteers and contractors understand the training they have received.

TCH maintains form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA) confirming that volunteers and contractors understand the training they have received.

The auditor reviewed the volunteer/contractor acknowledgement form for verification.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding volunteer and contractor training. No corrective action is required.

Standard 115.333: Resident education

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

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)?
  ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?
  ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. TCH Limited English Proficiency (LEP) Guidelines
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. PREA Comprehensive Education Curriculum
5. DCS form CS-0939, Youth Acknowledgment and Notification of Prison Rape Elimination Act (PREA)
6. PREA Youth Education Log
7. Resident Handbook
8. PREA Posters with Hotline Numbers for Outside Support Services (English and Spanish)
9. End Silence Brochure: Youth Speaking Up about Sexual Abuse in Custody (English and Spanish)
10. PREA Video: Sexual Abuse Prevention and Keeping You Safe PREA Educational Program
11. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with Intake Staff
2. Interviews with a Random Sample of Residents

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.333 (a)
PAQ: Residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. This information is provided in an age appropriate fashion.
Of residents admitted during the past 12 months:

1. The number who were given this information at intake: 23
2. The percent who were given this information within 10 days of intake:100%

During the intake process, residents receive information explaining, in an age appropriate fashion, the TCH zero-tolerance policy regarding sexual abuse, sexual assault, sexual misconduct, and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Resident education is accomplished through reviewing the PREA Comprehensive Education Curriculum, PREA brochures and resident handbooks.

The Case Manager confirmed residents are educated on the facility's zero-tolerance policy on sexual abuse and sexual harassment and how to report during intake. Written and verbal information on PREA is provided and explained to all residents within forty-eight (48) hours of intake. Residents interviewed confirmed they were informed of their right not to be sexually abused and sexually harassed, how to report, and their right not to be punished for reporting, during the intake process. They confirmed they received information about the facility's rules against sexual abuse and harassment through pamphlets and resident handbooks.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification. This information is documented with the Youth Acknowledgement of PREA. The auditor also reviewed relevant education materials including resident handbooks, pamphlets, and the PREA educational video.

115.333 (b)
PAQ: Of residents admitted during the past 12 months:

1. The number who received such education within 10 days of intake: 28
2. The percent who were given this information within 10 days of intake:100%

Written and verbal information on PREA is provided and explained to all residents within forty-eight (48) hours of arrival and includes at a minimum: TCH zero-tolerance policy regarding PREA; (2) prevention and intervention; (3) self-protection and how to avoid risk situations; (4) consequences for engaging in any type of sexual activity while at the facility; (5) how to obtain medical and mental health treatment and counseling; and (6) how to safely report sexual abuse.

The Case Manager Supervisor confirmed TCH ensures that residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents by providing the information in various educational formats and requiring the residents to sign an acknowledgment form stating they understand the information. She confirmed residents are made aware of these rights within forty-eight (48) hours after intake. Residents interviewed confirmed they

were informed of their right not to be sexually abused and sexually harassed, how to report, and their right not to be punished for reporting, during the intake process. Residents stated they received the information on their first or second day at the facility. They also confirmed they received information about the facility's rules against sexual abuse and harassment.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification. This information is documented with the Youth Acknowledgement of PREA. The auditor also reviewed relevant education materials including resident handbooks, pamphlets, and the PREA educational video.

115.333 (c)
PAQ: All residents were educated within 10 days of intake.

The Case Manager Supervisor confirmed all residents are educated on the facility's zero-tolerance policy on sexual abuse and sexual harassment regardless if they are transferred from other facilities.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification.

115.333 (d)
PAQ: The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

Appropriate provisions are made as necessary for residents who are of limited English proficiency, have disabilities (including those who are deaf or hard of hearing, those who are blind or have low vision), and those with psychiatric, speech or reading disabilities. TCH does not accept residents with an IQ of less than 70. Limited English proficient residents will be provided with an interpreter for assessments and to provide educational materials.

The auditor also reviewed relevant education materials including resident handbooks, pamphlets, and the PREA educational video.

115.333 (e)
PAQ: The agency maintains documentation of resident participation in PREA education sessions.

All residents sign DCS form CS-0939, Youth Acknowledgment and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have been notified and informed of PREA and on how to report incidents of sexual abuse, sexual assault, sexual misconduct, and sexual harassment.

The auditor reviewed youth acknowledgment forms of residents entering the facility in the past 12 months and residents interviewed for verification.

115.333 (f)
PAQ: The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

The facility ensures that key information is continuously and readily available or visible to residents through posters, resident handbooks, and resident PREA brochures. During the site review the auditor observed posters and PREA brochures are available in English and Spanish.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident education. No corrective action is required.

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 5.2 Professional Development and Training Requirements
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. TCH West Pre-Audit Questionnaire responses

TCH does not conduct any form of administrative or criminal sexual abuse investigations. Investigators are employed and trained by DCS. DCS investigators receive specialized training from the Tennessee Bureau of Investigations (TBI) and National Institute of Corrections (NIC) online training in sexual abuse investigations involving juveniles.

The DCS Special Investigators Unit Training Curriculum includes:
(1) What is PREA; (2) Confined Settings and Sexual Abuse Investigations; (3) Receiving a Referral for a Sexual Abuse Investigation in a Confined Setting; (4) Gathering Information during a Sexual Abuse Investigation in a Confined Setting; (5) Conducting a Sexual Abuse Investigation within a Confined Setting; (6) Interviewing Juvenile Sexual Abuse Victims; (7) Sexual Abuse Evidence Collection in Confinement Settings; (8) False Allegations; (9) Recanting Information; (10) Witnessing Sexual Abuse; (11) Substantiating a Case for Prosecution Referral; (12) Miranda Warning; and (13) Garrity Warning

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding specialized training: investigations. No corrective action is required.

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

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

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

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
4. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
5. TCH Employee Training Records
6. Training Certificates
7. TCH West Pre-Audit Questionnaire responses

Interviews:
Interviews with Medical and Mental Health Staff

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.335 (a)
PAQ: The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities.

1. The number of all medical and mental health care practitioners who work regularly at this facility who received the training: 3

2. The percent of all medical and mental health care practitioners who work regularly at this facility who received the training required by agency policy: 100%

TCH ensures that all full and part-time medical and mental health care practitioners who work regularly in its facilities receive training.

The interview with the Facility Director confirmed mental health staff have not received the specialized training topics regarding sexual abuse and sexual harassment.

115.335 (b)
PAQ: TCH does not employee medical staff that conduct forensic exams. Forensic medical examinations are performed offsite.

Policy states if medical staff employed by TCH conduct forensic examinations, such medical staff receives the appropriate training to conduct such examinations in compliance with PREA Standards.

The interview with the Facility Director confirmed forensic medical examinations are not conducted at TCH West.

115.335 (c)
PAQ: The agency maintains documentation showing that medical and mental health practitioners have completed the required training.

All agency employees, volunteers and contractors are required to sign form CS-0940, Employee Acknowledgement and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have read the DCS zero-tolerance policy and understand the training they have received. TCH will maintain documentation on all employees, volunteers and contractors who receive training on PREA.

115.335 (d)
Policy states medical and mental health care practitioners also receive the training mandated for employees under PREA Standards 115.331 or for contractors and volunteers under PREA Standards 115.332, depending upon the practitioner's status at the facilities.

The facility has no contracted or volunteer medical and mental health care practitioners.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is not fully compliant with this standard regarding specialized training for medical and mental health care. Corrective action has been completed.

115.335 (a)
Specialized training for mental health care staff was completed 01/14/2021. Training confirmation was received for verification.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained during classification assessments? ☒ Yes ☐ No

- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization
4. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Coordinator
2. Interview with the Staff Responsible for Risk Screening
3. Interviews with a Random Sample of Residents

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.341 (a)
PAQ: The agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents
The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.
In the past 12 months:
The number of residents entering the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 23
The policy requires that a resident's risk level be reassessed periodically throughout their confinement.

Policy states during the intake process, DCS form CS-0946 Assessment, Checklist and Protocol for Behavior and Risk for Victimization is administered to all children/youth within seventy-two (72) hours of admission to TCH. Residents are reassessed for risk of sexual victimization or risk of sexually abusing other residents every 90 days.

The auditor reviewed completed DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization examples for verification.

The Case Manager Supervisor confirmed he screens residents upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. He stated she screens residents for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The information is ascertained through conversations with residents during intake, medical and mental health screenings, and reviewing any relevant court records. Resident's risk levels are reassessed every ninety (90) days.

Residents interviewed confirmed when they first came to the facility, they were asked questions like whether they have ever been sexually abused, whether they identify with being gay, bisexual or

transgender, whether they have any disabilities, and whether they think they might be in danger of sexual abuse at the facility. They stated they were asked these questions the first or second day at the facility.

115.341 (b)
PAQ: Risk assessment is conducted using an objective screening instrument. DCS form CS-0946 Assessment, Checklist and Protocol for Behavior and Risk for Victimization objective screening instrument.

115.341 (c)
The assessment ascertains information about: (1) prior sexual victimization or abusiveness; (2) any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) current charges and offense history; (4) age; (5) level of emotional and cognitive development; (6) physical size and stature; (7) mental illness or mental disabilities; (8) intellectual or developmental disabilities; (9) physical disabilities; (10) the resident's own perception of vulnerability; and (11) any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Case Manager Supervisor confirmed the initial risk screening considers all aspects required by the standard.

115.341 (d) This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

The Case Manager Supervisor confirmed the information is ascertained through conversations with residents and reviewing any relevant documentation. She reviews the DCS intake packet.

115.341 (e) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

The PREA Coordinator confirmed the agency has outlined who can have access to a resident's risk assessment within the facility, in order to protect sensitive information from exploitation. The individuals include the clinical staff and residential counselors. The PREA Compliance Manager reported the information is available to case managers and treatment staff. The Case Manager Supervisor reported the information is available to case managers and treatment staff.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding obtaining information from residents. No corrective action is required.

Standard 115.342: Use of screening information

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

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

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

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

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

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

115.342 (g)

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

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization
4. At-Risk Protocol section of DCS form CS-0946
5. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Coordinator
2. Interview with the PREA Compliance Manager
3. Interview with Staff Responsible for Risk Screening

4. Interview with the Facility Director
5. Interview with Staff who Supervise Residents in Isolation – N/A
6. Interviews with Medical and Mental Health Staff
7. Interviews with Transgendered/Intersex/Gay/Lesbian/Bisexual Residents – N/A
8. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.342 (a)
PAQ: The agency/facility uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

The "At-Risk Protocol" section of form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization is initiated and completed on all residents who are identified as vulnerable for being at-risk of sexual victimization or identified as having the potential to victimize or perpetrate, especially in regards to sexually aggressive behavior.

The auditor reviewed the risk assessments for verification the facility uses information from the screening information to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The PREA Compliance Manager and Case Manager Supervisor confirmed the facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment by determining housing and room assignments. If the risk score is 9 or higher the youth would be considered at higher risk of victimization.

115.342 (b)
PAQ: The facility has a policy that residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months:

1. The number of residents at risk of sexual victimization who were placed in isolation: 0
2. The number of residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education, or special education services: 0
3. The average period of time residents at risk of sexual victimization who were held in isolation to protect them from sexual victimization: N/A

The Facility Director confirmed there is no use of isolation.

115.342 (c)
PAQ: The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Policy states lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other -assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The PREA Coordinator and PREA Compliance Manager confirmed gay, bisexual, transgender, or intersex residents are not placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor does the facility consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

115.342 (d)
PAQ: The agency or facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

TCH policy states in making housing and programming assignments for transgender or intersex residents, the facility considers on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

The PREA Compliance Manager confirmed housing and programming assignments for transgendered and intersex residents are considered on a case-by-case basis whether the placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

115.342 (e)
PAQ: Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

Policy states placement and programming assignments for transgender or intersex child/youth will be reassessed at least twice each year to review any threats to safety experienced by the child/youth and appropriateness of services.

The PREA Compliance Manager and Case Manager Supervisor confirmed placement and programming assignments are reassessed at least twice each year to review any threats to safety experienced by the resident. The youth would meet with the treatment team weekly.

115.342 (f)
PAQ: A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

TCH policy states with respect to his or her own safety, a LGBTI child/youth's own views will be given serious consideration.

The PREA Compliance Manager and Case Manager Supervisor confirmed a transgender or intersex resident's own views with respect to his or her own safety is given serious consideration.

115.342 (g)
PAQ: Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Policy states transgender youth must be given the opportunity to shower separately from other youth and they must be provided safety and privacy when dressing and undressing and using the bathroom.

The PREA Compliance Manager and Case Manager Supervisor confirmed transgender and intersex residents are given the opportunity to shower separately from other residents. All youth have their own shower.

115.342 (h)
PAQ: From a review of case files of residents at risk of sexual victimization who were held in isolation in the past 12 months, the number of case files that include BOTH:

1. A statement of the basis for facility's concern for the resident's safety, and
2. The reason or reasons why alternative means of separation cannot be arranged: N/A

If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:
(1) The basis for the facility's concern for the resident's safety; and
(2) The reason why no alternative means of separation can be arranged.

TCH does not use isolation.

115.342 (i)
PAQ: If a resident at risk of sexual victimization is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

TCH does not use isolation.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding use of screening information. No corrective action is required.

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

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

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

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

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

115.351 (c)

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

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

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Allegation Reporting Guidelines
4. Resident Handbook
5. Youth Grievance Form
6. PREA Posters with Hotline Numbers for Outside Support Services (English and Spanish)
7. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Compliance Manager
2. Interviews with a Random Sample of Staff
3. Interviews with a Random Sample of Residents
4. Interviews with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.351 (a)
PAQ: The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: Sexual abuse or sexual harassment; Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; AND Staff neglect or violation of responsibilities that may have contributed to such incidents.

The facility provides internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. These internal ways of reporting include telling any staff member or filing a grievance. Grievance forms and boxes are available for the residents. Residents can keep a pencil for writing grievances and the grievance boxes are checked daily.

Staff interviews confirmed residents can privately report sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, or staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment by calling the DCS hotline number. Residents stated they would report sexual abuse or sexual harassment that happened to them or someone else by telling staff, calling the hotline, or writing a grievance.

115.351 (b)
PAQ: The agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency has a policy requiring residents detained solely for civil immigration purposes be provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security.

Residents may also report externally to a public or private entity or office that is not part of the agency. This includes but is not limited to: (1) DCS Child Abuse Hotline at 1-877-237-0004 and (2) John L. Attorney or Guardian ad Litem. Residents may remain anonymous upon request.

Residents detained solely for civil immigration purposes are provided information with their resident handbook on how to contact relevant consular officials and relevant officials at the Department of Homeland Security. The facility has not had any residents detained solely for civil immigration purposes.

The PREA Compliance Manager identified the DCS hotline as one way residents can report sexual abuse or sexual harassment to a public or private entity that is not part of the agency. Calling the DCS hotline enables receipt and immediate transmission of resident repots of sexual abuse or sexual harassment to agency officials and allows the resident to remain anonymous upon request. Residents stated they would report sexual abuse or sexual harassment that happened to them or someone else by telling staff, calling the hotline, or writing a grievance. They also could identify someone that does not work at the facility they could report to.

The auditor observed posters with information for reporting sexual abuse or sexual harassment.

115.351 (c)
PAQ: The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports. The time frame that staff are required to document verbal reports:

Residents may get assistance in filing requests for administrative remedies relating to allegations of sexual abuse from third parties. Third parties may also file such requests on behalf of residents. If the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, staff members of the facility must document the resident’s decision to decline.

Pursuant to Tennessee Code Annotated 37-1-403, any person who has knowledge of or is called upon to render aid to any child/youth who is being sexually abused, sexually assaulted, or sexually harassed has the duty to report such abuse. In terms of PREA standards, this duty to report includes but is not limited to any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. All reports made verbally, in writing, anonymously, by third parties or by any other means must be reported.

Interviews with staff confirmed when a resident alleges sexual abuse or sexual harassment, he can do so verbally, in writing, anonymously and through third parties. Staff stated they document verbal reports. Most said immediately, but all stated they would document as soon as possible. Residents confirmed they can make reports of sexual abuse or sexual harassment either in person or in writing and someone else could make the report for them, so they do not have to give their name.

115.351 (d)
PAQ: The facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

The PREA Compliance Manager confirmed residents can keep pencils to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Grievance forms are available and the locked grievance boxes that are checked daily.

115.351 (e)
PAQ: The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents.

Staff report to the DCS Child Abuse Hotline at 1-877-237-0004.

Staff interviewed identified the DCS Child Abuse Hotline as a way for them to privately report sexual abuse and sexual harassment of residents.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident reporting. No corrective action is required.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of

explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☒ Yes ☐ No

115.352 (b)

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

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

115.352 (c)

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

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

115.352 (d)

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

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

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

115.352 (e)

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

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

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

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (f)

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

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

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

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

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

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

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 14.15 Reporting False Allegations of Child Sexual Abuse
3. DCS Policy 24.5 DOE Youth Grievance Procedures
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
6. Tennessee Code Annotated 37-1-413
7. Resident Handbook
8. Youth Grievance Form
9. Notice of Grievance Disposition
10. Grievance Disposition of Appeal
11. TCH West Pre-Audit Questionnaire responses

Interviews:
Interviews with Residents who Reported a Sexual Abuse - N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings:

This standard does not apply to TCH. All resident grievances regarding sexual abuse are investigated externally by DCS.

TCH does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. TCH policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. Agency policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. Policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The agency's policy requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint.

Residents may get assistance in filing requests for administrative remedies relating to allegations of sexual abuse from third parties, including other residents, staff members, family members, attorneys, and/or outside advocates. Those third parties may also file such requests on behalf of residents. If the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, staff members must document the resident's decision to decline.

Pursuant to Tennessee Code Annotated 37-1-413, any person who either verbally or by written/printed communication reports false accusations of sexual abuse commits a Class E felony. A report made in good faith upon reasonable belief of the alleged incident will not constitute a false report and may not be used as grounds for disciplinary action.

PAQ: In the past 12 months:
The number of grievances that were filed that alleged sexual abuse: Zero (0)
Residents

The auditor reviewed the resident handbook to determine that relevant information is provided.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding exhaustion of administrative remedies. No corrective action is required.

Standard 115.353: Resident access to outside confidential support services and legal representation

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

115.353 (a)

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

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local,

State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA

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

115.353 (b)

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

115.353 (c)

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

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

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 24.12 Access to Legal Counsel for Youth
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. Memorandum of Understanding with WRAP (Wo/Men's Resource and Rape Assistance Program)
5. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
6. Resident Handbook
7. Victim's Resources - Hotline Numbers and Outside Support Services
8. PREA Victim Advocate Numbers
9. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Facility Director
3. Interviews with a Random Sample of Residents
4. Interviews with Residents who Reported a Sexual Abuse - N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.353 (a)
PAQ: The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse by:

1. Giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) of local, State, or national victim advocacy or rape crisis organizations.
2. Enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

TCH provides residents with access to outside victim advocates for emotional support services related to sexual abuse. The facility has a MOU for victim advocates with WRAP (Wo/Men's Resource and Rape Assistance Program). Victim's resources with mailing addresses and telephone numbers, including toll free hotline numbers are provided to the residents. Information includes local, state, and national victim advocacy and rape crisis organizations. For persons detained solely for civil immigration purposes, immigrant services agency information is available with the resident handbook.

TCH West has a MOU for victim advocates with WRAP (Wo/Men's Resource and Rape Assistance Program).

Residents were knowledgeable of services available outside of the facility for dealing with sexual abuse if they ever need it.

115.353 (b)
PAQ: The facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. The facility informs residents, prior to giving them

access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law.

The facility informs residents, prior to giving them access, of the extent to which such communications will be monitored. Everyone in Tennessee is a mandated reporter. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605 requires all persons to report suspected cases of child abuse or neglect. The facility enables reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible. Telephone calls are monitored with sight, but not sound supervision.

Interviews with residents confirmed they were knowledgeable of mandatory reporting rules when having conversations with people from outside services.

115.353 (c)
PAQ: The agency or facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The agency or facility maintains copies of those agreements.

TCH West has a MOU for victim advocates with WRAP (Wo/Men's Resource and Rape Assistance Program).

115.353 (d)
PAQ: The facility provides residents with reasonable and confidential access to their attorneys or other legal representation. The facility provides residents with reasonable access to parents or legal guardians.

The Facility Director and PREA Compliance Manager confirmed the facility would provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

Residents confirmed the facility allows them to see or talk with their lawyer or another lawyer and they are allowed to talk with that person privately. Residents also confirmed the facility allows them to see or talk with their parents or someone else such as a legal guardian.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident access to outside support services and legal representation. No corrective action is required.

Standard 115.354: Third-party reporting

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

115.354 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
4. Sexual Abuse and Reporting Guidelines
5. TCH West Pre-Audit Questionnaire responses

Document (Corrective Action):

1. Third-Party reporting information is published at: https://www.tennesseechildrenshome.org/about-us/pathways-financials/.

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.354 (a)
PAQ: The agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. This information is not distributed publicly.

Third parties, including parents, advocates, other residents, or any other person may report allegations of resident sexual abuse or sexual harassment by through the TCH website at https://www.tennesseechildrenshome.org/about-us/pathways-financials/.

Also, the TCH website has a link to the DCS Child Abuse Reporting website at:

https://apps.tn.gov/carat/. Hotline case managers are available to assist callers in reporting abuse.

Corrective Action
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding third-party reporting. Corrective action has been completed.

115.354 (a)
The agency's website has been updated, and third-party reporting information has been published at: https://www.tennesseechildrenshome.org/about-us/pathways-financials/.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

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

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

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

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

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

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. TCH Reporting Abuse and Neglect Policy
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
5. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Facility Director
3. Interviews with a Random Sample of Staff
4. Interviews with Medical and Mental Health Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.361 (a)

PAQ: The agency requires all staff to report immediately and according to agency policy:

1. Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency.
2. Any retaliation against residents or staff who reported such an incident.
3. Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605 Laws and TCH requires all staff to report immediately and according to policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All allegations of sexual abuse must be reported immediately to the DCS Child Abuse Hotline at 1-877-237-0004. Failure to comply with “duty to report” requirements will result in disciplinary action up to and including termination and/or criminal charges.

Staff confirmed the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. They stated they would report to their supervisor and DCS.

115.361 (b)

PAQ: The agency requires all staff to comply with any applicable mandatory child abuse reporting laws.

Duty to Report - As per Tennessee Code Annotated 37-1-403 and 37-1-605 Pursuant to TCA 37-1-403 and 37-1-605, any person who has knowledge of or is called upon to render aid to any child/youth who is being sexually abused, sexually assaulted or sexually harassed has the duty to report such abuse.

Staff confirmed PREA training includes how to comply with relevant laws related to mandatory reporting of sexual abuse.

115.361 (c)

PAQ: Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Staff confirmed the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. They stated they would report to their supervisor and DCS.

115.361 (d)
Medical and mental health practitioners are required to report sexual abuse to DCS. They are mandated to follow Duty to Report laws. Medical and mental health practitioners are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

An interviews with the Facility Director confirmed he discloses the limitations of confidentiality and his duty to report at the initiation of services to a resident. He confirmed he is required by law to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment upon learning of it. He reported he has not become aware of such incidents.

115.361 (e)
Upon receiving any allegation of sexual abuse, the Facility Director or his designee shall promptly report the allegation to the alleged victim's parents or legal guardians, unless TCH has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of DCS, the report shall be made to the alleged victim's Family Services Worker instead of the parents or legal guardians.

The Facility Director and PREA Compliance Manager confirmed when the facility receives an allegation of sexual abuse the allegation is reported to the PREA Coordinator, DCS Child Abuse Hotline and the victim's legal guardians as appropriate. This notification would occur immediately, but no longer than twenty-four hours. If a juvenile court retains jurisdiction over the alleged victim, the allegation would be reported to the juvenile's attorney. All allegations of sexual abuse and sexual harassment are reported to the DCS Special Investigations Unit. TCH does not conduct administrative or criminal investigations.

115.361 (f)
TCH policy requires all allegations of sexual abuse must be reported to the DCS Child Abuse Hotline at 1-877-237-0004. DCS ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse/assault/misconduct/harassment.

The Facility Director confirmed all allegations of sexual abuse and sexual harassment (including those from third-party and anonymous sources) are reported directly to designated facility investigators.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding staff and agency reporting duties. No corrective action is required.

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Protocol: First Responder Guidelines for Sexual Assaults
4. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Agency Head (President)
2. Interview with the Facility Director
3. Interviews with a Random Sample of Staff

Site Review Observations:
Observations during on-site review of physical plant

Findings:
PAQ: When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay).
In the past 12 months:

1. The number of times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse: Zero (0)

TCH requires that upon learning a resident is subject to a substantial risk of imminent sexual abuse immediate action shall be taken to protect the resident.

The President confirmed immediate action would be taken to protect a resident subject to a substantial risk of imminent sexual abuse. These actions would include housing changes for youth and staff reassignment. The Facility Director stated the facility would protect a resident subject to a substantial risk of imminent sexual abuse immediately through housing changes and increasing supervision. Staff interviewed confirmed they would immediately separate a resident subject to a substantial risk of imminent sexual abuse from a potential perpetrator and provide close observation.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding agency protection duties. No corrective action is required.

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. TCH West Pre-Audit Questionnaire responses
4. Allegation Reporting Guidelines

Interviews:

1. Interview with the Agency Head (President)
2. Interview with the Facility Director

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.363 (a)
PAQ: The agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The agency's policy also requires that the head of the facility notify the appropriate investigative agency. In the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: Zero (0)

Policy states If victimization occurred while a child/youth was confined at another facility/agency, the head of the facility/agency that received the allegation promptly, within seventy-two hours, notifies the head of the facility/agency where the alleged abuse occurred and reports the abuse incident directly to DCS Child Abuse Hotline at 1-877-237-0004.

115.363 (b)
PAQ: Agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.

Policy requires, the head of the facility/agency that received the allegation promptly, within seventy-two hours, notifies the head of the facility/agency where the alleged abuse occurred.

115.363 (c)
PAQ: The agency or facility documents that it has provided such notification within 72 hours of receiving the allegation.

115.363 (d)
PAQ: Agency/facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: Zero (0)

DCS ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse, sexual assault, sexual misconduct, and sexual harassment.

The President confirmed DCS would be the point of contact. The Facility Director confirmed if an allegation is received from another facility or agency that an incident of sexual abuse or harassment occurred in the facility, DCS would conduct the investigation. He stated there are no examples of this occurring.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding reporting to other confinement facilities. No corrective action is required.

Standard 115.364: Staff first responder duties

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

115.364 (a)

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

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

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

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

115.364 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Protocol: First Responder Guidelines for Sexual Assaults
4. Allegation Reporting Guidelines
5. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interviews with Security Staff and Non-security Staff First Responders
2. Interviews with a Random Sample of Staff

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.364 (a)
PAQ: The agency has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

1. Separate the alleged victim and abuser;

2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
3. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
4. If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

In the past 12 months, the number of allegations that a resident was sexually abused: Zero (0)

TCH policy requires staff follow the DCS Protocol: First Responder Guidelines for Sexual Assault for guidelines on responding to sexual assaults.

Interviews with Non-Security Staff confirmed they were knowledgeable of their first responder duties.

115.364 (b) The agencies policy requires that if the first staff responder is not a security staff member, that responder shall be required to:

1. Request that the alleged victim not take any actions that could destroy physical evidence.
2. Notify security staff.

Of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: Zero (0)

TCH does not employ security staff.

Interviews with staff confirmed they were knowledgeable of their first responder duties.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding staff first responder duties. No corrective action is required.

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Protocol: First Responder Guidelines for Sexual Assaults
4. TCH West Pre-Audit Questionnaire responses

Interview:

1. Interview with the Facility Director

Site Review Observation:
Observations during on-site review of physical plant

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

The DCS Protocol: First Responder Guidelines for Sexual Assaults coordinates 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 Director confirmed that after the initial actions taken by the facility, all allegations are reported to DCS and the facility follows the directions provided by DCS. The DCS Protocol: First Responder Guidelines for Sexual is followed.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding a coordinated response. No corrective action is required.

Standard 115.366: Preservation of ability to protect residents from contact with abusers

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

115.366 (a)

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. TCH West Pre-Audit Questionnaire responses

Interview:
Interview with the Agency Head (President)

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):
115.366 (a)
PAQ: The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since the last PREA audit.

The President confirmed TCH has not entered into or renewed any collective bargaining agreements.

115.366 (b)
TCH has not entered into or renewed any collective bargaining agreements.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding preservation of the ability to protect residents from contact with abusers. No corrective action is required.

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

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

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

115.367 (b)

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

115.367 (c)

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

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct

and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

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

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

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

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

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

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

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

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. TCH Protection of Reports of Misconduct Policy
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Agency Head (President)
2. Interview with the Facility Director
3. Interview with the Designated Staff Member Charged with Monitoring Retaliation (Facility Director)
4. Interview with Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) - N/A
5. Interview with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):
115.367 (a)
PAQ: The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff.

The agency designates staff member(s) or charges department(s) with monitoring for possible retaliation.
The name(s) of the staff member(s): Jeremy Northrop
The title(s) of the staff member(s): Facility Director

Retaliation or negative consequences for reporting sexual abuse or sexual harassment or cooperating with sexual abuse or sexual harassment investigations is not tolerated and will result in disciplinary action up to and including termination. All staff members are required to report immediately and

according to TCH policy retaliation against residents who reported sexual abuse or sexual harassment. Staff members have a duty to report staff neglect or violations of responsibilities that may have contributed to an incident or retaliation.

115.367 (b)
The President stated the facility would protect residents and staff from retaliation for sexual abuse or sexual harassment allegations through housing changes or transfers and removal of alleged abusers. The Facility Director stated the facility would make housing changes or transfers, remove alleged abusers, and provide emotional support services. The Case Manager Supervisor stated the role she plays in preventing retaliation against residents and staff who report sexual abuse or sexual harassment, or against those who cooperate with sexual abuse or sexual harassment investigations is making housing changes or transfers, removal of alleged abusers, and providing emotional support services. She stated the different measures she would take to protect residents and staff from retaliation would be the same. She stated she explains what retaliation is during intake. She confirmed she would initiate contact with residents who have reported sexual abuse.

115.367 (c)
PAQ: The agency and/or facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff.
The length of time that the agency and/or facility monitors the conduct or treatment: 90 days
The agency/facility acts promptly to remedy any such retaliation.
The agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need.
The number of times an incident of retaliation occurred in the past 12 months: Zero (0)

For a period of ninety (90) days following a report, TCH monitors the treatment of residents or staff that made a report and the residents who were reported to be abused to identify attempts at retaliation or negative consequences and will act immediately to remedy any such actions. Monitoring should include, but not limited to: (1) Resident disciplinary reports, housing, or program changes; (2) Negative performance reviews or staff reassignments; and (3) Periodic status checks of residents. The agency continues monitoring beyond ninety (90) days if evidence indicates a continued need.

The Facility Director stated the facility would make housing changes or transfers, remove alleged abusers, and provide emotional support services. The Case Manager Supervisor stated things she looks for to detect possible retaliation include changes in behavior, withdrawal, and verbal cues. She monitors resident disciplinary reports, consequences that are extreme, and interactions between abusers and victims. She stated she would monitor the conduct and treatment of residents and staff who report the sexual abuse of a resident or were reported to have suffered sexual abuse for 90 days. If there is concern that potential retaliation might occur, the maximum length of time that the facility would monitor conduct and treatment would be until a youth is released from the facility.

115.367 (d)
Policy states monitoring will include periodic status checks of residents. The Case Manager Supervisor stated things she looks for to detect possible retaliation include changes in behavior, withdrawal, and verbal cues. She monitors resident disciplinary reports, consequences that are extreme, and interactions between abusers and victims.

115.367 (e)

Policy states if any individual involved in a report expresses fear of retaliation, the agency takes appropriate measures to protect the individual that includes segregated housing, as applicable, if voluntarily requested by the individual.

The President stated if an individual who cooperates with an investigation expresses fear of retaliation, the agency takes measures to protect that individual against retaliation including staff reassignments and housing changes for residents. The Facility Director stated the facility would make housing changes or transfers, remove alleged abusers, and provide emotional support services.

115.367 (f)
TCH's responsibility to monitor retaliation will terminate if the allegation is unfounded.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding agency protection against retaliation. No corrective action is required.

Policy Suggestion
115.367 (b)
Policy would be enhanced and fully inclusive of the standard provisions by including protective measures against retaliation.

The standard provision states, 'The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations."

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. TCH West Pre-Audit Questionnaire responses

Interview:

1. Interview with the Facility Director

Site Review Observations:
Observations during on-site review of physical plant

Findings:
PAQ: The facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged.
The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise.
In the past 12 months:

1. The number of residents who allege to have suffered sexual abuse who were placed in isolation: Zero (0)

If a resident who alleges to have suffered sexual abuse is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

TCH does not use of segregated housing or isolation to protect a resident who is alleged to have suffered sexual abuse. One-on-one supervision and other protective measures would be used.

The Facility Director confirmed TCH does not use isolation.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding post-allegation protective custody. No corrective action is required.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

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

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

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

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

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

115.371 (f)

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

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

115.371 (g)

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

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

115.371 (h)

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

115.371 (i)

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

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
  ☒ Yes ☐ No

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 14.7 Child Protective Services Investigation Track
3. DCS Policy 14.25 Special Investigations Unit Child Protection Services Investigations
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with PREA Coordinator
2. Interview with PREA Compliance Manager
3. Interview with Facility Director
4. Interview with Investigative Staff (DCS)

Site Review Observations:

1. Observations during on-site review of physical plant

Findings (By Provision):
115.371 (a)
PAQ: The agency/facility does not have a policy related to criminal and administrative agency investigations.

DCS is responsible for allegations of sexual abuse or sexual harassment. The DCS investigator stated once a case is received, it takes less than 24 hours to initiate an investigation following an allegation of sexual abuse or sexual harassment. The investigator confirmed she handles anonymous or third-party reports of sexual abuse and sexual harassment in the same manner as all investigations. She begins by interviewing the individual who reported the allegation.

115.371 (b)
DCS investigators receive specialized training in sexual abuse investigations involving juveniles. The DCS investigator confirmed she received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings through classroom and computer-based training. She confirmed she received the required training,

115.371 (c)
The DCS Investigator gathers all evidence, reviews video surveillance footage if available, and interviews alleged victims, suspected perpetrators, and witnesses. The investigation will include reviewing any prior complaints and reports of sexual abuse involving the suspected perpetrator. The investigator will not terminate the investigation solely because the victim recants the allegation.

The DCS investigator confirmed the first steps in initiating an investigation is contacting the facility where an allegation of sexual abuse or sexual harassment has been made and requesting all available information. This occurs within 24 hours. She then travels to the facility to review any video footage that may be available, and conducts interviews with the alleged victim, alleged perpetrator, and all witnesses. Direct and circumstantial evidence she would be responsible for gathering in an investigation of an incident of sexual abuse would include video footage, interviews, statements, third-party information, etc.

115.371 (d)
PAQ: The agency does not terminate an investigation solely because the source of the allegation recants the allegation.

The DCS investigator confirmed an investigation does not terminate if the source of the allegation recants the allegation.

115.371 (e)
The DCS investigator confirmed when she discovers evidence that a prosecutable crime may have taken place, she consults with prosecutors before conducting compelled interviews.

115.371 (f)
The DCS investigator confirmed she judges the credibility of an alleged victim, suspect, or witness based on evidence. She stated under no circumstance, does she require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation.

115.371 (g)
The DCS investigator confirmed the efforts she makes during an administrative investigation to determine whether staff actions or failures to act contributed to the sexual abuse include investigating the allegation and coordinating with the DCS PREA Coordinator. She confirmed she documents administrative investigations in written reports. The reports include incident reports, interviews, and all available evidence.

115.371 (h)
The DCS investigator confirmed criminal investigations documented. There were no criminal investigations during the audit period. The investigations are documented in the appropriate TFACTS incident reporting section.

115.371 (i)
PAQ: Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The number of sustained allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit: Zero (0)

The DCS investigator confirmed cases are referred for prosecution only when there are substantiated allegations of conduct that appears to be criminal. The auditor reviewed two allegations of staff-on-youth sexual harassment that were referred to law enforcement.

115.371 (j)
PAQ: The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

DCS policy sates documentation is maintained for a period of no less than the last day of employment of an allegedly perpetrating employee, plus five (5) years and seven (7) years after a resident's twenty-second (22nd) birthday.

115.371 (k)
The DCS investigator confirmed an investigation continues when a staff member alleged to have committed sexual abuse or sexual harassment terminates employment prior to a completed investigation into his/her conduct.

115.371 (l)
Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

115.371 (m)
The Facility Director and PREA Compliance Manager stated if an outside agency investigates allegations of sexual abuse, the facility remains informed of the progress of a sexual abuse investigation through direct contact with DCS. DCS provides updates to the Facility Director. The PREA Coordinator stated she communicates with DCS concerning investigations.

The DCS investigator confirmed when an outside agency investigates an incident of sexual abuse in this facility, she would support the investigative process and communicate with the outside agency to remain informed of the progress.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding criminal and administrative agency investigations. No corrective action is required.

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 14.7 Child Protective Services Investigation Track
3. DCS Policy 14.25 Special Investigations Unit Child Protection Services Investigations
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. TCH West Pre-Audit Questionnaire responses

Interview:
Interview with Investigative Staff (DCS)

Site Review Observations:
Observations during on-site review of physical plant

Findings:
PAQ: The agency imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

DCS policy states a report of child abuse by the alleged perpetrator may be classified as substantiated if there is a preponderance of evidence, in light of the entire record, which substantiated the individual

committed physical, severe or child sexual abuse, as defined in Tennessee Code Annotated 37-1-102 or 37-1-602.

The DCS investigator confirmed she refers to the preponderance of the evidence to substantiate allegations of sexual abuse or sexual harassment.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding evidentiary standard for administrative investigations. No corrective action is required.

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

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

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

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

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

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)

2. DCS Policy 14.25 Special Child Protective Services Investigations
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with Facility Director
2. Interview with DCS Investigator
3. Interview with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.373 (a)
PAQ: The agency has a policy requiring that any resident who makes an allegation that he or he suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency.
In the past 12 months:

1. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility: Zero (0)
2. Of the investigations that were completed of alleged sexual abuse, the number of residents who were notified, verbally or in writing, of the results of the investigation: N/A

CPS notifies the DCS Family Services Worker and the TCH Facility Director of the outcome of an investigation. The DCS Family Services Worker informs the alleged victim directly as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. They provide the resident with written notification.

The Facility Director confirmed the facility notifies a resident who makes an allegation of sexual abuse, that the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

The DCS Investigator confirmed she is aware that when a resident makes an allegation of sexual abuse, the resident must be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

115.373 (b)
PAQ: If an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation.
In the past 12 months:

1. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency: Zero (0) All allegations were sexual harassment.
2. Of the outside agency investigations of alleged sexual abuse that were completed, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigation: N/A

115.373 (c)

PAQ: Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency/facility has determined that the allegation is unfounded) whenever:

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

There has not been a substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in the past 12 months.

115.373 (d)

PAQ: Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever:

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

115.373 (e)

PAQ: The agency has a policy that all notifications to residents described under this standard are documented.

In the past 12 months:

1. The number of notifications to residents that were made pursuant to this standard: Zero (0)
2. The number of those notifications that were documented: N/A

115.373 (f)

An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding reporting to residents. No corrective action is required.

Policy Suggestion

The auditor suggests policy is updated to be fully inclusive of the standard provisions.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Tennessee Children's Home Personnel Policies and Procedures Manual for Employees
4. TCH West Pre-Audit Questionnaire responses

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.376 (a)
PAQ: Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

The TCH personnel policies and procedures outlines the disciplinary process. If it is determined that this policy has been violated, corrective action will be taken up to and including termination.

115.376 (b)
In the past 12 months:

1. The number of staff from the facility that have violated agency sexual abuse or sexual harassment policies: Zero (0)
2. The number of those staff from the facility that have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: Zero (0)

The TCH personnel policies and procedures outlines the disciplinary process. If it is determined that this policy has been violated, corrective action will be taken up to and including termination.

115.376 (c)
PAQ: Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.
In the past 12 months, the number of staff from the facility that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies: Zero (0)

115.376 (d)
PAQ: All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.
In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: Zero (0)

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding disciplinary sanctions for staff. No corrective action is required.

Policy Suggestion
The auditor suggests policy is updated to be fully inclusive of the standard provisions.

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

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

115.377 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
4. Volunteer Manual
5. Volunteer Application
6. TCH West Pre-Audit Questionnaire responses

Interview:
Interview with Facility Director

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.377 (a)
PAQ: Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents.
In the past 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents.

The facility maintains form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA) confirming that volunteers and contractors understand the training they have received. The acknowledgement form states the agency's zero-tolerance policy and requires that any contractor or volunteer who violates the policy will be terminated and referred for criminal prosecution unless the activity was clearly not criminal.

115.377 (b)
PAQ: The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

The Facility Director stated in the case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, the facility would take remedial measures and prohibit further contact with residents. The contractor or volunteer would have no contact with the residents during the investigation.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding corrective action for contractors and volunteers. No corrective action is required.

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

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

115.378 (b)

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

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

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

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

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

115.378 (f)

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

115.378 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Student Handbook
4. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with Facility Director

2. Interviews with Medical and Mental Health Staff

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.378 (a)
PAQ: Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse.
In the past 12 months:

1. The number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: Zero (0)
2. The number of criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility: Zero (0)

115.378 (b)
In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible.
In the past 12 months:

1. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse: Zero (0)
2. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: N/A
3. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied access to other programs and work opportunities: N/A

TCH does not use isolation as a disciplinary sanction. The Facility director stated disciplinary sanctions residents are subject to following an administrative or criminal finding the resident engaged in resident-on-resident sexual abuse would include possible transfer to another facility. The decision would be made on a case-by-case basis. The sanctions would be proportionate to the nature and circumstances of the abuses committed, the residents' disciplinary histories, and the sanctions imposed for similar offenses by other residents with similar histories. Isolation is not used as a disciplinary sanction.

115.378 (c)
The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed.

The Facility Director stated mental disability or mental illness is considered when determining sanctions.

115.378 (d)

PAQ: The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. If the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, the facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Access to general programming or education is not conditional on participation in such interventions.

The Facility Director stated if the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The Facility Director and therapist have been trained on providing services to offenders.

115.378 (e)
PAQ: The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact.

The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

115.378 (f)
PAQ: The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

115.378 (g)
PAQ: The agency prohibits all sexual activity between residents. The agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding disciplinary sanctions for residents. No corrective action is required.

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with Staff Responsible for Risk Screening
2. Interviews with Residents who Disclosed Sexual Victimization at Risk Screening

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.381 (a)
PAQ: All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner. The follow-up meeting was offered within 14 days of the intake screening. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who disclosed prior victimization during screening who were offered a follow up meeting with a medical or mental health practitioner: 100% The PAQ states there were zero (0) residents who disclosed prior victimization during screening.

Policy states if screening or assessments indicates that a child/youth has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, designated staff ensures that the child/youth is offered a follow-up meeting with a medical or mental health practitioner within fourteen (14) days of the intake screening.

The Case Manager Supervisor confirmed that if screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, a follow-up meeting is offered with a psychologist. She confirmed the meeting would occur within fourteen (14) days.

115.381 (b)
PAQ: All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are offered a follow-up meeting with a mental health practitioner. The follow-up meeting was offered within 14 days of the intake screening. Mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who previously perpetrated sexual abuse, as indicated during screening, who were offered a follow up meeting with a mental health practitioner: 100%

The PAQ states there were zero (0) residents who disclosed previously perpetrated sexual abuse.

Policy states if screening indicates that a child/youth was previously perpetrated sexual abuse/assault/misconduct/harassment, whether it occurred in an institutional setting or in the community, designated staff ensure that the child/youth is offered a follow-up meeting with a mental health practitioner within fourteen (14) days of the intake screening.

The Case Manager Supervisor confirmed that if screening indicates that a resident previously perpetrated sexual abuse, whether in an institutional setting or in the community, a follow-up meeting is offered with a psychologist. She confirmed the meeting would occur within fourteen (14) days.

115.381 (c)
PAQ: Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners.

115.381 (d)
PAQ: Medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting unless the resident is under the age of 18.

The Facility Director confirmed informed consent from residents is required for residents 18 and older before reporting about prior sexual victimization that did not occur in an institutional setting.

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

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

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

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

115.382 (c)

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

115.382 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Protocol-First Responder Guidelines for Sexual Assault
4. DCS PREA Refusal of Medical Treatment Form
5. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interviews with Medical and Mental Health Staff
2. Interviews with Residents who Reported a Sexual Abuse – N/A
3. Security Staff and Non-Security Staff First Responders

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.382 (a)
PAQ: Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency

medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis.

Policy states children/youth who are the victim of sexual abuse are provided prompt and appropriate medical treatment and counseling.

The Facility Director stated resident victims of sexual abuse receive immediate and unimpeded access to emergency medical treatment and crisis intervention services. He stated the nature and scope of these services would be determined according to Mobile Crisis.

115.382 (b)
Staff were knowledgeable of their first responder duties. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners.

115.382 (c)
PAQ: Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis.

The Jackson-Madison County General Hospital and WRAP (Wo/Men's Resource and Rape Assistance Program) has a PREA Program would offer resident victims of sexual abuse timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The Facility Director confirmed victims of sexual abuse offered timely information and services concerning sexually transmitted infection prophylaxis at the hospital.

115.382 (d)
PAQ: Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Policy states no child/youth victim is denied access to treatment resources and/or services for failing to fully disclose details to internal investigators, outside law enforcement investigators, and/or medical/mental health staff.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding access to emergency medical and mental health services. No corrective action is required.

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.383 (a)

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

115.383 (b)

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

115.383 (c)

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

115.383 (d)

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

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.383 (f)

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

115.383 (g)

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

115.383 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS PREA Refusal of Medical Treatment Form
4. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interviews with Medical and Mental Health Staff
2. Interviews with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.383 (a)
PAQ: The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

Policy states children/youth who are the victim of sexual abuse are provided an assessment by a mental health professional and mental health counseling as needed.

The auditor observed the facility has mental health staff at the facility. Medical treatment is provided offsite.

115.383 (b)
Policy states follow-up services and referrals, as applicable, for continued care following transfer to, or placement in other facilities, or release from custody.

The Facility Director stated residents who have been victimized would be provided follow-up services and counseling.

115.383 (c)
The Facility Director confirmed medical and mental health services exceed the community level of care.

115.383 (d) N/A
Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

TCH West is an “all-male” facility.

115.383 (e) N/A
If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

TCH West is an “all-male” facility.

115.383 (f)
PAQ: Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

These services would be offered by Jackson-Madison County General Hospital and WRAP (Wo/Men's Resource and Rape Assistance Program) through Tenncare.

115.383 (g)
PAQ: Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Policy states no child/youth victim is denied access to treatment resources and/or services for failing to fully disclose details to internal investigators, outside law enforcement investigators, and/or medical/mental health staff.

Services would be offered at no cost through Tenncare.

115.383 (h)

PAQ: The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

Policy states children/youth who are the victim of sexual abuse are provided an assessment by a mental health professional.

The Facility Director confirmed the facility conducts a mental health evaluation of all known resident-on-resident abusers and offers treatment if appropriate. After learning about the abuse history of a resident, an evaluation is conducted within forty-eight (48) hours.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers. No corrective action is required.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

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

115.386 (b)

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

115.386 (c)

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

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Sexual Abuse Critical Incident Review Form
4. Survey of Sexual Victimization
5. TCH West Pre-Audit Questionnaire responses

Interviews:

1. Interview with Facility Director
2. Interview with PREA Compliance Manager
3. Interview with Incident Review Team Member

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.386 (a)
PAQ: The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation unless the allegation has been determined to be unfounded. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents: Zero (0).

TCH will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation involving a PREA-related incident, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

115.386 (b)
PAQ: The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.
In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility that were followed by a sexual abuse incident review within 30 days, excluding only "unfounded" incidents: Zero (0)

The review will occur within thirty (30) days of the conclusion of the DCS investigation and TCH notification by DCS of the conclusion of the investigation. The review team will consist of the case manager, treatment director, counselor, campus director, and supervisors.

115.386 (c)
PAQ: The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

The review team will consist of the case manager, treatment director, counselor, campus director, and supervisors.

The Facility Director confirmed the facility has a sexual abuse incident review team.

115.386 (d)
PAQ: The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submits such report to the facility head and PREA compliance manager.

The review team shall: (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings and recommendations, including recommendations for improvement and submit the report to the Executive Director, the PREA Coordinator, and DCS as required.

The PREA Compliance Manager confirmed if the facility conducts a sexual abuse incident review, the facility prepares a report of its findings from the review, including any determinations any recommendations for improvement. The PREA Compliance Manager is a member of the sexual abuse incident review team.

115.386 (e)
PAQ: The facility implements the recommendations for improvement or documents its reasons for not doing so.

The facility implements the recommendations or documents reasons for not doing so and provides this information to the TCH risk management team and DCS as required.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding sexual abuse incident reviews. No corrective action is required.

Standard 115.387: Data collection

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

115.387 (a)

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

115.387 (b)

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

115.387 (c)

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

115.387 (d)

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

115.387 (e)

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

115.387 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape
3. Survey of Sexual Victimization Substantiated Incident Form (Juvenile)
4. TCH West Pre-Audit Questionnaire responses

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.387 (a)
PAQ: The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization conducted by the Department of Justice.

Policy states the agency will collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions as instructed ty the PREA Coordinator. DCS/Agencies aggregate and incident-based sexual abuse data at least annually. The incident-based data collected includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

115.387 (b)
PAQ: The agency aggregates the incident-based sexual abuse data at least annually.

115.387 (c)
PAQ: The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization conducted by the Department of Justice.

Policy states the incident-based data collected includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization conducted by the Department of Justice.

The auditor reviewed the instrument for verification.

115.387 (d)
PAQ: The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Policy states DCS/Agencies maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. DCS/Agencies also obtain incident - based and aggregated data from every contract agency with which it contracts for the confinement of its residents.

115.387 (e) N/A
The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

TCH does not contract with other facilities for the confinement of its residents.

115.387 (f) N/A
Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The DOJ did not request TCH provide all such data from the previous calendar year.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data collection. No corrective action is required.

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

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

115.388 (c)

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

115.388 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Survey of Sexual Victimization
4. TCH 2019/2020 Annual PREA Report

5. TCH West Pre-Audit Questionnaire responses

Interviews:
1. Interview with the Agency Head (President)
2. Interview with the PREA Coordinator
3. Interview with the PREA Compliance Manager

Site Review Observations:
Observations during on-site review of physical plant

Findings (by provision):
115.388 (a)
PAQ: The agency reviews data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:
1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole.

Policy states DCS/Agencies review data collected and aggregated pursuant to PREA Standards 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:
1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of its findings and corrective actions for each facility, as well as DCS/Agencies as a whole.

The President stated the facility uses incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, response policies, practices, and training to identify problem areas and take corrective action as needed. The PREA Coordinator and PREA Compliance Manager confirmed the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training.

115.388 (b)
PAQ: The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse.

Policy states annual reports include a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse.

The auditor reviewed the 2019/2020 annual report published on the agency's website. The agency's annual report does not include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse

115.388 (c)
PAQ: The agency makes its annual report readily available to the public at least annually through its website. The annual reports are approved by the agency head.

Policy states DCS/Agencies reports are approved by the Director and made readily available to the public through its website or through other means, as applicable.

The auditor reviewed the 2019/2020 annual report published on the agency's website. The annual reports are approved by the agency head.

115.388 (d)
PAQ: When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted.

Policy states DCS/Agencies may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but the nature of the material redacted is indicated.

The PREA Coordinator stated names and identifying information will be redacted from the annual report. The auditor observed no personal identifiers were included in the annual report. However, agency does not indicate the nature of material redacted.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is not fully compliant with this standard regarding data review for corrective action. Corrective action has been completed.

115.388 (b)
The agency's annual report was updated to include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse.

115.388 (c)
The annual reports were updated to include agency head approval.

115.388 (d)
The agency updated the reports to indicate the nature of material redacted.

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
  ☒ Yes ☐ No

115.389 (b)

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

115.389 (c)

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

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. TCH Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. TCH 2019/2020 Annual PREA Report
4. TCH West Pre-Audit Questionnaire responses

Interview:

1. Interview with the PREA Coordinator

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.389 (a)

PAQ: The agency ensures that incident-based and aggregate data are securely retained.

Policy states DCS/Agencies ensure that data collected pursuant to PREA Standards 115.387 are securely retained.

The PREA Coordinator confirmed the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training. She confirmed the data collected is securely retained and TCH takes corrective action on an ongoing basis based on the data.

115.389 (b)

PAQ: Agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website.

Policy states DCS/Agencies make all aggregated sexual abuse data from facilities under its direct control and contract agency facilities with which it contracts, readily available to the public at least annually through its website or through other means, as applicable.

The auditor reviewed the 2019/2020 annual report published on the agency's website.

115.389 (c)

PAQ: Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

Policy states before making aggregated sexual abuse data publicly available, DCS/Agencies removes all personal identifiers.

The auditor reviewed the 2019/2020 annual report published on the agency's website. The auditor observed no personal identifiers.

115.389 (d)

PAQ: The agency maintains sexual abuse data sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless Federal, State, or local law requires otherwise.

DCS/Agencies maintain sexual abuse data collected pursuant to PREA Standards 115.387 for at least ten (10) years after the date of its initial collection unless Federal, State, or local law requires otherwise.

The auditor reviewed historical sexual abuse data.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data storage, publication, and destruction. No corrective action is required.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

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

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

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

1. TCH West Pre-Audit Questionnaire responses
2. Policy Review
3. Research
4. Documentation Review
5. Interviews
6. Observations during onsite review of facility

Conclusion:
During the three-year period starting on August 20, 2013, and the current audit cycle, TCH was audited in 2014, 2017, and 2020. This is the third audit for TCH West.

The auditor was given access to, and the ability to observe, all areas of the audited facility. The auditor was permitted to conduct private interviews with residents at the facility. The auditor sent an audit notice to the facility more than six weeks prior to the on-site audit. The facility confirmed the audit notice was posted by emailing pictures of the posted audit notices. The audit notice contained contact information for the auditor. The residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. No confidential information or correspondence was received.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding frequency and scope of audits. No corrective action is required.

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

1. TCH West Pre-Audit Questionnaire responses
2. Policy Review
3. Documentation Review
4. Interviews
5. Observations during onsite review of facility

Conclusion:
All TCH PREA Audit Reports are published on the agency's website at: https://www.tennesseechildrenshome.org/about-us/pathways-financials/. This is the third audit for TCH West.

Corrective Action
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding audit contents and findings. No corrective action is required.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

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

Robert Burns Latham March 31, 2021

Auditor Signature **Date**

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

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