# PREA AUDIT: AUDITOR'S SUMMARY REPORT
# COMMUNITY CONFINEMENT FACILITIES

NATIONAL PREA RESOURCE CENTER

BJA Bureau of Justice Assistance U.S. Department of Justice

[Following information to be populated automatically from pre-audit questionnaire]

| | | | |
|---|---|---|---|
| **Name of facility:** | Second Judicial District Department of Correctional Services - Beje Clark Residential Center | | |
| **Physical address:** | 510 5th Street, Ames, Iowa 50010 | | |
| **Date report submitted:** | August 22, 2014 | | |
| **Auditor Information** | | | |
| **Address:** | 864 Great Egret Circle SW, Sunset Beach, N.C. 28468 / 11820 Parklawn Dr., Suite 240 Rockville, MD 20852 | | |
| **Email:** | stephen.huffman@aol.com / stephen.huffman@nakamotogroup.com | | |
| **Telephone number:** | 614-940-4696 | | |
| **Date of facility visit:** | August 6 and 7, 2014 | | |
| **Facility Information** | 515-232-1511 | | |
| **Facility mailing address:** *(if different from above)* | 818 15th Street SW / P.O. Box 1226, Mason City, Iowa 50402 | | |
| **Telephone number:** | 641-424-3817 | | |
| **The facility is:** | ☐ Military | ☐ County | ☐ Federal |
| | ☐ Private for profit | ☐ Municipal | ☒ State |
| | ☐ Private not for profit | | |
| **Facility Type:** | ☐ Community treatment center<br>☐ Halfway house<br>☐ Alcohol or drug rehabilitation center | ☒ Community based confinement facility<br>☐ Mental health facility | ☐ Other: |
| **Name of Facility Head:** | Leah Noel | **Title:** | Residential Manager |
| **Email address:** | leah.noel@iowa.gov | **Telephone number:** | 641-422-3830 |
| **Name of PREA Compliance Manager (if applicable):** | Jon Grotelueschen | **Title:** | PPO Supervisor / PREA Coordinator |
| **Email address:** | jon.grotelueschen@iowa.gov | **Telephone number:** | 515-574-4027 |
| **Agency Information** | | | |
| **Name of agency:** | Second Judicial District Department of Correctional Services - Beje Clark Residential Center | | |
| **Governing authority or parent agency:** *(if applicable)* | Board of Directors | | |
| **Physical address:** | 510 5th Street, Ames, Iowa 50010 | | |
| **Mailing address:** *(if different from above)* | 818 15th Street SW / P.O. Box 1226, Mason City, Iowa 50402 | | |
| **Telephone number:** | 641-424-3817 | | |
| **Agency Chief Executive Officer** | | | |
| **Name:** | Amanda Milligan | **Title:** | District Director |

| | | | |
|---|---|---|---|
| **Email address:** | amanda.milligan@iowa.gov | **Telephone number:** | 515-574-4021 |
| **Agency-Wide PREA Coordinator** | | | |
| **Name:** | Jon Grotelueschen | **Title:** | PPO Supervisor/PREA Coordinator |
| **Email address:** | jon.grotelueschen@iowa.gov | **Telephone number:** | 515-574-4027 |

# AUDIT FINDINGS

**NARRATIVE:**

**[Following information to be populated automatically from auditor compliance tool]**

See attachment:

**DESCRIPTION OF FACILITY CHARACTERISTICS:**

**[Following information to be populated automatically from auditor compliance tool]**

See attachment:

**SUMMARY OF AUDIT FINDINGS:**

**[Following information to be populated automatically from auditor compliance tool]**

See attachment:

# Audit Findings

## Second Judicial District Department of Correctional Services

## Beje Clark Residential Center

## Mason City, Iowa

**Narrative:**

The site visit for the PREA audit of the Second Judicial District Department of Correctional Services-Beje Clark Residential Center, Mason City, Iowa was conducted on August 6 and 7, 2014. During the two days the auditor toured the facility and conducted formal staff and resident interviews and reviewed documentation. Fifteen male and female randomly selected residents from the three housing units were interviewed. Twelve staff from all shifts was interviewed including District Director Amanda Milligan. Staff were questioned about PREA training, how to report, to whom to report, filing reports, available interventions, conducting interviews, evidence collection, follow up and monitoring retaliation.

An entrance meeting was held with Leah Noel, Residential Manager and Jon Grotelushen, PREA Coordinator to discuss the audit schedule of activities. Following the entrance meeting I toured the facility from 8:30 a.m. to 9:30 a.m.

In the past twelve months the facility has had three sexual assault / harassment allegation cases. On October 1, 2013 a male resident filed an allegation that a female Resident Officer had been too aggressive during a pat-down search getting too close to his buttocks and pubic area. Video footage of the pat-down showed a proper pat-down process and the allegation was found to be unfounded. On January 13, 2014 a female resident filed an allegation against a male Resident Officer. The incident occurred in the bedroom area during a head count. The resident claimed the Officer came into her room multiple times while she was in bed. She stated the Officer was inspecting her roommates sleeping area and asked an additional Officer to observe the area as well. She stated she got up to get dressed and was partially clothed and the Officer remained there with the room door open and would not leave. She also stated she was not fully clothed below the waist. The Officers stated she was wrapped in a blanket and not naked in front of them. Due to the testimonies and video footage the allegation was determined to be unfounded. On June 24, 2014 a male resident filed an allegation against a female resident for grabbing his buttocks. The incident happened in front of staff and the

female resident admitted to grabbing the male resident's buttocks and the incident was determined to be substantiated.

**Description of Facility Characteristics:**

The community-based residential center serving seven counties was opened in 1992. The primary goal of the facility is assisting offenders in re-entering society through identifying and addressing specific need areas in order to lower the chance of recidivating. The typical average length of stay for the residents is four to six months.

The center is a 51 bed male (39) and female (12) facility with an average population the past twelve months of 45 residents. The facility population at the time of the audit was 48. The center is a one story building constructed of bricks and mortar. The residents housing area consists of two and three person bedrooms. The center uses local hospital, Mercy Medical Center for medical and mental health care. The center has five trained investigators for administrative investigations and uses the Department and the Iowa Department of Corrections Investigative Division for criminal investigations. The center has an excellent relationship with the local Crisis Intervention Center for advocacy programs. Ms. Mary Ingham, Executive Director was contacted prior to the audit to discuss any sexual abuse / harassment allegations at the center and stated the facility enforces the PREA concept at the facility and has found no issues at the facility.

The resident population consists of state offenders on parole, probation, work release, operating while intoxicated (OWI) and also Federal Bureau of Prison clients for supervision. Facility policy and rules limits contact between the male and female residents. Male and female residents are housed in separate wings and have separate hygiene areas and dayrooms. They do share common visiting rooms that are under direct supervision. The Beje Clark Residential Center provides supervision and programming in a structured environment that promotes stability, accountability and long term behavior change. Residents are required to work and fulfill their financial responsibilities, including family support, victim restitution, court costs and payments toward debts, taxes and rent to the Iowa Department of Corrections. Residents must undergo appropriate assessments and follow-through with all recommended treatment. The residents receive programming in the following areas; Individual Counseling, referrals to substance abuse treatment, sex offender programming, mental health treatment, batterer's education and operating while intoxicated (OWI) programming.

They also receive cognitive skills training, employment assistance, financial management assistance, GED education and training, HIV/AIDS awareness and social skills development. During each residents stay, they are awarded furloughs from the facility based on satisfactory performance. Those who successfully complete their stay are moved to regular Probation or Parole supervision.

The auditor found the staff and residents to be very aware of PREA. The staff was very knowledgeable about their responsibilities to ensure a safe facility. They were all aware of reporting responsibilities, preservation of evidence, as well as dealing with victims and abusers of sexual assault / harassment. The staff has had extensive training on how to identify signs of sexual assault / harassment and how to deal and treat victims of sexual assault and or harassment.

**Summary of Audit Findings:**

An exit meeting was held August 7, 2014 with the following persons in attendance: Amanda Milligan, District Director via telephone conference call, Jon Grotelushen, PREA Coordinator and Leah Noel, Residential Manager.

**Number of standards exceeded: 0**

**Number of standards met: 39**

**Number of standards not met: 0**

[Following information to be populated automatically from auditor compliance tool]

**Standard number here** 115.211 STANDARD INSERTED HERE Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The facility has a zero tolerance level for sexual abuse and harassment per policy 101-IAB page 1. Human Resource documentation reviewed also indicated a zero tolerance. Staff sign documentation stating they understand the zero tolerance policy. The PREA Coordinator reports to the Assistant District Director.

[ space for comments extends as needed here]

**Standard number here** 115.212 STANDARD INSERTED HERE Contracting with other entities for the confinement of residents.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The agency has not contracted with other entities for the purpose of resident confinement.

[ space for comments extends as needed here]

**Standard number here** 115.213 STANDARD INSERTED HERE Supervision and monitoring.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The District Director and other executive staff continuously monitor the staffing plan to ensure staffing levels are always met using part-time staff. The staffing plan was reviewed and determined to be adequate. The plan is reviewed annually and approved by the District Director. Policy 101-2A I-4 page 11 covers elements of the standard.

[ space for comments extends as needed here]

**Standard number here** 115.215 STANDARD INSERTED HERE Limits to cross-gender viewing and searches.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



The facility does not conduct cross-gender checks per policy 101-3A page. Policy states if searches must be completed in emergency situations they would be documented. Policy also states transgender residents would shower separately. Staff announce themselves when

entering housing area of opposite gender. Policy 101-3B-F pages 1 and 2 cover all elements of the standard.

**[Following information to be populated automatically from auditor compliance tool]**

| **Standard number here** | 115.216 STANDARD INSERTED HERE | Residents with disabilities and residents who are limited English proficient. |
|---|---|---|

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The facility ensures that residents with any disabilities have equal opportunities to participate in or benefit from all programming and to prevent, detect and respond to any sexual abuse/harassment incident. Policy 101-4A-C page 2 covers all the elements of the standard.

**[ space for comments extends as needed here]**

| **Standard number here** | 115.217 STANDARD INSERTED HERE | Hiring and promotion decisions. |
|---|---|---|

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Based upon interviews with District Director and H.R. Supervisor the elements of the standard are met. Background checks are completed at least every 5 years and completed for any new hire or promotion. Policy 101-5A-H pages 1-3 cover the elements of the standard. Background checks were reviewed.

**[ space for comments extends as needed here]**

| **Standard number here** | 115.218 STANDARD INSERTED HERE | Upgrades to facilities and technology. |
|---|---|---|

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Based upon interviews with District Director and other executive staff, upgrades and modifications are always considered considered to improve the operation to ensure the safety of the residents. There were camera modifications and upgrades the past 12 months. Policy 101-6A-B page 3 cover the elements of the standard.

**[ space for comments extends as needed here]**

| **Standard number here** | 115.221 STANDARD INSERTED HERE | Evidence protocol and forensic medical examinations. |
|---|---|---|

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



Policy 102-1A-F page 1 covers all elements of the standard. There are no youth housed at the facility. The facility has MOUs with the Mason City Police Department and IDOC Investigation Division to perform criminal investigations. The facility has

MOU with local hospital, Mercy Medical Center for forensic examinations and the Crisis Intervention Center for advocacy services.

**[Following information to be populated automatically from auditor compliance tool]**

**Standard number here** 115.222 STANDARD INSERTED HERE Policies to ensure referrals of allegations for investigations.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The facility had three allegations of sexual abuse / harassment the past 12 months and two were found to be unsubstantiated and one was found to be substantiated. Policy 102-2A-D page 1 covers all elements of the standard. The facility has three trained investigators for administrative investigations who were trained by the Moss Group. The Mason city Police Dept. and IDOC Investigation Division conduct the criminal investigations.

**[ space for comments extends as needed here]**

**Standard number here** 115.231 STANDARD INSERTED HERE Employee training.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Facility training curriculum and traning records were reviewed. All staff are trained including executive staff, line staff and volunteers. Interviews with staff indicated they clearly understand PREA policies and standards. Policy 103-A 1-4 pages 1 and 2 cover all elements of the standard.

**[ space for comments extends as needed here]**

**Standard number here** 115.232 STANDARD INSERTED HERE Volunteer and contractor training.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 103-B1-3 page 1 covers all elements of the standard. Volunteers and contractors are required to sign documentation indicating they have recieved and understand the PREA policy and standard. Documentation was reviewed by the auditor.

**[ space for comments extends as needed here]**

**Standard number here** 115.233 STANDARD INSERTED HERE Resident education.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



Residents recive PREA education through the intake process upon entering the facility. The recive the rules and regulations, handbook and other materials that include the Crisis Intervention Center hot-line number. Through resident

interviews, they clearly understand PREA and understand they have a right to be free from sexual abuse/harassment. They also know the means of reporting abuse/harassment if need be. Posters are posted throughout the facility. Policy 103-C1-5 pages 1 and 2 cover all elements of the standard.

**[Following information to be populated automatically from auditor compliance tool]**

**Standard number here** 115.234 STANDARD INSERTED HERE Specialized training, investigations.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The facility has 3 trained investigators through the Moss Group to conduct administrative investigations. The facility has the Mason City Police Department and IDOC Investigation Division to conduct criminal investigations. Policy 103-D1-2 page 2 covers all elements of the standard.

**[ space for comments extends as needed here]**

**Standard number here** 115.235 STANDARD INSERTED HERE Specialized training; Medical and mental health care.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The facility uses local hospital, Mercy Medical Center for medical and mental health services. An MOU has been established with the hospital.

**[ space for comments extends as needed here]**

**Standard number here** 115.241 STANDARD INSERTED HERE Screening for risk of victimization and abusiveness.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 104-A1-4 page 1 covers all elements of the standard and risk screening process. Review of the SVP screening instrument ad interviews with staff and residents confirmed that residents are safely placed in housing ad programs.

**[ space for comments extends as needed here]**

**Standard number here** 115.242 STANDARD INSERTED HERE Use of screening information.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



Through interviews with Residential Officers, who were very knowledgable of the screening instrument, knowing how to place residents in a safe environment for housing and programs. Policy 104-B1-6 page 1 covers all elements of the standard.

There are no consent decrees or pending judgements for the facility.

**[Following information to be populated automatically from auditor compliance tool]**

**Standard number here** 115.251 STANDARD INSERTED HERE Resident reporting.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Resident and Residential Officer interviews indicated residents are aware on when, how to report any sexual abuse/harassment incidents either verbally, written to staff, third party or external agencies. They are also aware they can report anonymously and privately. Policy 105-A1-4 page 1 covers all elements of the standard.

**[ space for comments extends as needed here]**

**Standard number here** 115.252 STANDARD INSERTED HERE Exhaustion of administrative remedies.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 105-B1-15 pages 1 and 2 cover all elements of the standard allowing residents to file grievances for sexual abuse/harassment. Decisions are made in 90 day period on the merits of the grievance filed. Residents are also allowed third parties to file grievances for them.

**[ space for comments extends as needed here]**

**Standard number here** 115.253 STANDARD INSERTED HERE Residents access to outside confidential support services.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 105-C1-2 page 2 covers all elements of the standard allowing residents access to outside confidential support services. The local crisis center address and telephone number is posted near resident telephones. Resident interviews indicated residents are aware of the crisis center information.

**[ space for comments extends as needed here]**

**Standard number here** 115.254 STANDARD INSERTED HERE Third-party reporting.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



Resident interviews indicated residents were aware of Third Party agencies they could report to. Agencies included Mason City Police Department and also family members and

attorney. The facility has an excellent relationship with the Crisis Intervention Center. I interviewed a representative from the crisis center who indicated the facility has excellent PREA culture. Policy 105-D page 3 covers all elements of the standard.

**[Following information to be populated automatically from auditor compliance tool]**

**Standard number here** STANDARD INSERTED HERE 115.261 Staff and agency reporting duties.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Random staff interviews indicated staff are aware and well trained in reporting and responding to any sexual abuse/harassment incident. They report all incidents immediately to the supervisors. Policy 106-A1-6 page 1 covers all elements of the standard. There are no juveniles housed at the facility.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE 115.262 Agency protection duties.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 106-B1 page 1 covers all elements of the standard. Random staff interviews including District Director indicated staff are aware of their duty to protect residents and take immediate action of separation and preserving evidence.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE 115.263 Reporting to other confinement facilities.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 106-C1-3 page 1 covers all elements of the standard. Staff interviews including District Director and executive staff, the facility will comply with the standard and cooperate fully with the reporting facility ~~and~~ document notification.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE 115.264 Staff first responder duties.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



Interviews with Residential Officers, Parole Officers and other random staff indicated staff understand and comply with all elements of the standard, ie. separation, collection

of evidence, preserving incident scene and reporting to supervision. Policy 106-D1a-d page 1 covers all elements of the standard.

**[Following information to be populated automatically from auditor compliance tool]**

**Standard number here** 115.265 STANDARD INSERTED HERE Coordinated response.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

A detailed PREA Plan and policy 106-E1 page 1 cover all elements of the standard., is in place for a coordinated response by first responders. Responders included are law enforcement, medical and mental health providers and advocacy crisis center. Staff interviews indicated staff are aware of the plan.

**[ space for comments extends as needed here]**

**Standard number here** 115.266 STANDARD INSERTED HERE Preservation of ability to protect residents from contact with abusers.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Facility Human Resource documentation and AFSCME agreement were reviewed and the documents protect residents from sexual abuse / harassment by staff. Staff will be disciplined for involvement of any sexual abuse/harassment incidents. Policy requires staff to sign documents indicating awareness of discipline.

**[ space for comments extends as needed here]**

**Standard number here** 115.267 STANDARD INSERTED HERE Agency protection against retaliation.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 106-F1-4 pages 1 and 2 covers all elements of the standards. The facility has a retaliation monitor who monitors incidents for retaliation for at least 90 days or longer if needed. there were no incidents of retaliation the past 12 months.

**[ space for comments extends as needed here]**

**Standard number here** 115.271 STANDARD INSERTED HERE Criminal and administrative agency investigations.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



The facility has three trained staff who conduct administrative investigations, through the Moss Group. The facility uses the Mason City Police Department and IDOC Investigation Division to conduct criminal investigations. The County

Attorney Office is used for prosecution of criminal cases. Policy 107-A1-9 pages 1 and 2 cover all elements of the standard.

**[Following information to be populated automatically from auditor compliance tool]**

**Standard number here** STANDARD INSERTED HERE 115.272 Evidentiary standards for administrative investigations.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 107-B-1 page 1 covers all elements of the standard when determining the preponderance of the evidence, when to determine whether allegations of sexual abuse/harassment are either substantiated, unsubstantiated or unfounded. Staff interviewed indicated they understood the requirements.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE 115.273 Reporting to residents.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Staff interviews and Review Team interviews indicated residents are notified verbally whether the investigation of the incident was determined to be substantiated, unsubstantiated or unfounded. Policy 107-C1-4 pages 1 and 2 and 107-A10 page 1 cover all elements of the standard.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE 115.276 Disciplinary sanctions for staff.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Human Resource documentation, AFSCME agreement and policy 108-A1-4 page 1 covers all elements of the standard. The documents state staff are subject to be disciplined if involved in a sexual abuse/harassment incident. There were no disciplines the past 12 months.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE 115.277 Corrective action for contractors and volunteers.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



Policy 108-B1-2 page 1 and 108-C1-7 pages 1 and 2 cover all elements of the standard. Policy states services will cease with volunteer and/or contractor immediately until conclusion of investigation. The contractors and volunteers are aware of policy.

[Following information to be populated automatically from auditor compliance tool]

**Standard number here** STANDARD INSERTED HERE 115.278 Disciplinary sanctions for residents.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Resident disciplinary sanctions are clearly stated in the handbook and residents are informed during the intake process. Policy 108-C1-7 page 1 covers all elements of the standard.

[ space for comments extends as needed here]

**Standard number here** STANDARD INSERTED HERE 115.282 Access to emergency medical and mental health services.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The facility has MOU with local hospital, Mercy Medical Center for medical and mental health services. Policy 109-A1-3 page 1 covers all elements of the standard. Residents are not responsible for medical or mental health service fees.

[ space for comments extends as needed here]

**Standard number here** STANDARD INSERTED HERE 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy 109-B1-8 page 1 covers all elements of the standard including proper follow-up care equal to or consistent to community care at no cost to the resident. The facility attempts to conduct a mental health evaluation of all known residents on resident abusers within 60 days after learning of the abuse history.

[ space for comments extends as needed here]

**Standard number here** STANDARD INSERTED HERE 115.286 Sexual abuse incident reviews.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**



Policy 110-A1-4 page 1 covers all elements of the standard. The facility has a Review Team that includes upper level staff. The (3) allegations were reviewed and reports were found to be accurately reported.

**[Following information to be populated automatically from auditor compliance tool]**

**Standard number here** STANDARD INSERTED HERE 115.287 Data collection.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The facility and the IDOC Investigation Division collect, review and maintain all data concerning sexual abuse/harassment incidents. The data is reviewed at least annually. Policy 110-B1-4 page 1 covers all elements of the standard.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE 115.288 Data review for corrective action.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Data was reviewed by the auditor and verified annual report was reviewed and approved by the District Director and placed on website. Names are redacted from the report. Policy 110-C1-4 pages 1 & 2 covers all elements of the standard.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE 115.289 Data storage, publication and destruction.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

The data is retained by the facility and the IDOC Investigative Division administrative offices for safety and security of the data. Policy 110-D1-4 page 2 covers all elements of the standard.

**[ space for comments extends as needed here]**

**Standard number here** STANDARD INSERTED HERE End of Report

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

**[ space for comments extends as needed here]**

| **Standard number here** | STANDARD INSERTED HERE |
|---|---|

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

**[ space for comments extends as needed here]**

**[Following information to be populated automatically from auditor compliance tool]**

**AUDITOR CERTIFICATION:**

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

Auditor Signature

August 21, 2014

Date