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

☐ **Interim** ☒ **Final**

Date of Report 10/4/2018

Auditor Information

Name: James L. Roland Jr.	**Email:** james.roland@nakamotogroup.com
Company Name: The Nakamoto Group, Inc.	
Mailing Address: 11820 Parklawn Drive, Suite 240	**City, State, Zip:** Rockville, MD 20852
Telephone: 302-468-6535	**Date of Facility Visit:** September 12-13, 2018

Agency Information

Name of Agency: Fletcher House		**Governing Authority or Parent Agency** *(If Applicable)*: Volunteers of America Delaware Valley	
Physical Address: 531 Market Street		**City, State, Zip:** Camden, New Jersey 08102	
Mailing Address: Same as above		**City, State, Zip:** Same as above	
Telephone: 856-854-4660		**Is Agency accredited by any organization?** ☒ Yes ☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency mission: Volunteers of America Delaware Valley provides community-based assistance to populations in need so that they can lead self-fulfilled, independent lives.

Agency Website with PREA Information: www.voadv.org

Agency Chief Executive Officer

Name: Dan Lombardo	**Title:** CEO
Email: DZippy@voadv.org	**Telephone:** 856-854-4660

Agency-Wide PREA Coordinator

Name: Demetre Pough	**Title:** Quality Assurance
Email: Dpough@voadv.org	**Telephone:** 856-854-4660

PREA Coordinator Reports to: Pat McKernan	Number of Compliance Managers who report to the PREA Coordinator 0

Facility Information

Name of Facility: Fletcher House			
Physical Address: 517 Penn St., Camden, New Jersey 08102			
Mailing Address (if different than above):			
Telephone Number: 856-964-6966			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Type:	☐ Community treatment center	☒ Halfway house	☐ Restitution center
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center	
	☐ Other community correctional facility		

Facility Mission: Volunteers of America Delaware Valley provides community-based assistance to populations in need so that they can lead self-fulfilled, independent lives.

Facility Website with PREA Information: www.voadv.org

Have there been any internal or external audits of and/or accreditations by any other organization? ☒ Yes ☐ No

Director

Name: Lola Oyesanmi	**Title:** Program Director
Email: LOyesanmi@voadv.org	**Telephone:** 856-338-6960

Facility PREA Compliance Manager

Name: Lola Oyesanmi	**Title:** Program Director
Email: LOyesanmi@voadv.org	**Telephone:** 856-338-6960

Facility Health Service Administrator

Name: NA	**Title:**
Email:	**Telephone:**

Facility Characteristics

Designated Facility Capacity: 84	**Current Population of Facility:** 78		
Number of residents admitted to facility during the past 12 months			84
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			78
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			83
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			83
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	☒ Adults	☐ Juveniles	☐ Youthful residents
Average length of stay or time under supervision:			18 months
Facility Security Level:			Low
Resident Custody Levels:			Low
Number of staff currently employed by the facility who may have contact with residents:			29
Number of staff hired by the facility during the past 12 months who may have contact with residents:			24
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			4

Physical Plant

Number of Buildings: 1	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	2
Number of Open Bay/Dorm Housing Units:	None

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): The Fletcher House utilizes a video camera system for video surveillance. Cameras are placed strategically throughout the facility to ensure the safety and security of both residents and staff.

Medical

Type of Medical Facility:	The facility does not have a medical operation
Forensic sexual assault medical exams are conducted at:	Our Lady of Lourdes Hospital, Camden, NJ

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	4
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	0

Audit Findings

Audit Narrative

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

Overview

The on-site Prison Rape Elimination Act (PREA) compliance audit of the Fletcher House, located in Camden, NJ. was conducted on September 12-13, 2018 by U.S. Department of Justice certified PREA auditor, James L. Roland Jr., Nakamoto Group, Inc. The standards used for this audit became effective August 20, 2012. The auditor conducted an opening meeting, toured the entire facility, interviewed a random sample of staff and residents, and reviewed PREA related supportive documentation. Upon completion of the audit process, a closing meeting was held with the administrative staff to discuss the audit process, preliminary findings, and the post-audit process. Employees at the facility were found to be extremely courteous, cooperative, and professional. All areas of the facility were clean and well maintained. During the closing meeting, the Auditor thanked the staff for their hard work and dedication to the PREA process.

Pre-Audit Phase

On August 1, 2018, PREA Audit Notices (in English and Spanish) were sent to the facility and were posted the same day. The notices were posted throughout the facility. Postings were in place for six weeks prior to the on-site-audit and observed by the auditor during the tour. No confidential correspondence were received from residents or staff.

Fletcher House staff completed the Pre-Audit Questionnaire (PAQ) which was provided to the facility on August 1, 2018. The completed PAQ and supporting documentation was received by the auditor on August 20, 2018 via email. The documentation reviewed included, but not limited to, educational materials, training logs, posters, brochures, agency policies and procedures, forms, and organizational charts.

On August 21, 2018, the auditor requested additional information be available for review during the on-site audit such as staff rosters, resident rosters (including any residents who self-identified as lesbian, gay, bisexual, transgender, or intersex (LGBTI), residents that were Limited English Proficient (LEP), investigations packets of resident allegations of sexual abuse/harassment, and examples of the intake screening instrument. These documents were provided and reviewed during the on-site audit.

On-Site Audit Phase

An opening meeting was held on the morning of September 12, 2018 at the Fletcher House with administrative staff. The audit schedule and process were discussed during the meeting. Including the auditor, those present at the meeting were:

- Program Director
- Assistant Program Director

The auditor was provided a private conference room to work and conduct confidential interviews. All requested files and rosters, both staff and resident, were made available on the first day of the audit.

Site Review

Immediately following the opening meeting, a tour of the facility was conducted. The auditor was escorted by the Facility Director and Assistant Facility Director. The auditor was given unimpeded access to all areas of the facility.

During the tour, the Auditor reviewed PREA related documentation and materials located on bulletin boards and pertinent entries made in electronic logs. The auditor assessed camera surveillance, physical supervision, and electronic monitoring capabilities. Additional areas of focus during the facility tour included, but were not limited to, levels of staff supervision, and limits to cross-gender viewing. Residents can shower, dress, and use the toilet facilities without exposing themselves to employees of the opposite gender. Informal conversations with employees and residents regarding the PREA standards were conducted during the tour. Postings (in English and Spanish) regarding PREA violation reporting and the agency's zero tolerance policy for sexual abuse and sexual harassment were prominently displayed in all living units, meeting areas, and throughout the facility. PREA postings displaying the New Jersey Department of Human Services (NJDHS) Adult Protective Services Abuse hotline and the Services Empowering Right of Victims (SERV) contact number were placed on the walls of the visitation area in full view. Audit notice postings with the PREA auditor's contact information were posted in the same areas. The auditor notice postings were posted on August 1, 2018.

Resident Interviews

At the time of the on-site audit there were 78 male residents housed at Fletcher House. Sixteen residents were interviewed and no residents were identified as LEP or physically disabled. There were no residents who self-identified as LGBTI housed at the facility at the time of the audit and no residents refused to be interviewed. Interviews were conducted using the Department of Justice (DOJ) protocols to assess resident's knowledge of PREA and the reporting mechanisms available to them.

Staff Interviews

Fletcher House has a total of 29 staff and 18 staff members were interviewed, including eight direct care staff (from all three shifts) and ten administrative/specialized staff. The administrative staff included the Program Director, PREA Coordinator, Treatment Director, Contract Administrator, Human Resource Administrator, Treatment Coordinator, Assistant Director, and Program Assistant. All staff members have been trained to act as first responders when a PREA related incident occurs.

The Auditor connected telephonically with the Program Director of Services Empowering Rights of Victims (SERV) regarding the Memorandum of Understanding (MOU) that exists between the two agencies. It was confirmed that SERV will provide services to Fletcher House including, but not limited to, a 24- hour-per-day, seven-days-per-week Sexual Assault Hotline and provide a victim advocate for each victim of sexual assault and coordinate a forensic examination by a Sexual Assault Nurse Examiner (SANE). Forensic examinations are conducted a trained SANE at Our Lady of Lourdes Hospital, Camden, New Jersey.

File Review

Following the interviews, the Auditor reviewed the files requested during the pre-audit phase. The Auditor reviewed five (23%) of Fletcher House personnel files to establish compliance with background checks and 29 (100%) of the training files to establish compliance with PREA training mandates. The facility does not employ any contractors that have direct contact with the residents. Screening and intake procedures were evaluated by reviewing ten (30%) of the resident files which included the Vulnerability Assessment Instrument. Ten (30%) of the resident education verification documentation files were also reviewed.

Investigations

During the current auditing period, there were no reported allegations of sexual abuse/sexual harassment. All investigations are handled by the Camden Police Department (CPD), New Jersey Department of Corrections (NJDOC) Office of Community Programs (OCP), or the NJDOC Special Investigation Unit (SID). Information is transmitted quickly to the appropriate investigating agency. The PREA Coordinator is responsible for receiving verbal and telephonic referrals 24 hours a day, seven days a week. Additionally, abuse investigation outcomes and general protective services assessment outcomes are submitted to, reviewed by, and finalized by the PREA Coordinator.

Closeout

A closing meeting was held with the administrative staff on September 13, 2018. Discussions centered around the audit process, preliminary findings, and the post-audit process. The Auditor thanked the staff for their hard work and dedication to the PREA process.

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.

Fletcher House is owned and operated by Volunteers of America, Delaware Valley, Inc. (VOA). It is a private, not-for-profit operation providing services exclusively for the NJDOC. The facility provides re-entry services inclusive of a work release program. Residents are received from the NJDOC within two years of their parole date. Fletcher House provides evidence-based treatment interventions in an effort to reduce the risk of re-offending while promoting public safety. Fletcher House provides services/interventions from a social learning theoretical basis, while utilizing cognitive-behavioral programming to address criminogenic risk/needs. All residents are accessed via the Level of Service Inventory-Revised tool and residents are referred for treatment or recommended to participate in programs based on that assessment.

The Fletcher House provided an array of behavioral programs which include Thinking for a Change, SMART Recovery, Pathways to Change, Choices, CALM (Anger Management), Life Skills (budgeting, goal setting, etc.), Family Violence Prevention Program, Job Readiness and motivational enhancement groups.

The facility was renovated in the late 1980s from what was originally two older (possibly turn of the century) homes. The structure now houses the entire operation under one roof. This is a two story structure with fourteen multiple bedrooms providing for a rated capacity of 84. All the residents assigned to this facility are male. The facility has a small kitchen. The basement serves as a recreational/weight lifting area. The main floor houses administrative offices, the Control Room, a day room, and the laundry room. The second floor is exclusively used for housing. This facility is located near Rutgers University and blends in quite well with the surrounding architecture. At the time of the tour, the facility was in good repair for a facility of its age and construction, and housekeeping was good. The mood of the resident population seemed appropriate and staff morale appeared to be good.

Summary of Audit Findings

The summary should include the number of standards exceeded, number of standards met, and number of standards not met, ***along with a list of each of the standards in each category****. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

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

Overview

During the auditing period, Fletcher House reported zero allegations of sexual abuse/harassment. There is a well established zero- tolerance culture at the facility and information available throughout the facility addressing all areas of PREA. The agency, Volunteers of America Delaware Valley, maintains a broad Central Administration set of PREA policies as well as specific, detailed policies for the program. A random review of five (23%) personnel files for background checks and 29 (100%) of the training files established compliance with PREA training mandates and revealed that hiring and promotion practices are consistent with sexual abuse safety measures.

The Auditor found the facility administration to have a strong commitment to PREA and the zero tolerance policy. Significant time and resources have been employed to ensure a safe environment for both the residents and staff at Fletcher House which includes an environment free of sexual abuse/harassment. Throughout the entire audit process the professionals caring for the residents have proven to be organized, efficient, and well-prepared.

Staff Interviews

Interviews with staff revealed they received and had a good understanding of PREA policies. They were knowledgeable about their roles in the prevention, reporting, and their responsibilities in the event of a PREA related incident, particularly first responder duties. They were able to verbalize the steps they would take if they were the first responder to a PREA related incident. Reporting mechanisms were conspicuously displayed throughout the facility and residents and staff members were aware of all reporting methods available to them. A review of the Fletcher House staff training curriculum and other related documents to support the finding that all staff have received comprehensive PREA training. Staff appeared truly interested and vested with the residents and expressed a true desire to see the residents succeed.

Resident Interviews

Interviews with residents indicated they have a good understanding of the PREA safeguards and the zero tolerance policy. Comprehensive resident PREA education is provided in written form (i.e. Resident Handbook, entrance packet), personal instruction, videos, and posters. Ten (8%) of the completed Vulnerability Assessment Instruments were reviewed by the Auditor

which revealed that intake and classification assessments are efficient and seamless in addressing referrals based on victimization or abusiveness screening data. Residents acknowledged the admissions screening process included questions regarding any history of sexual abuse or victimization and whether they would like to identify a sexual preference. Residents stated during interviews that they were aware of how to report abuse internally and externally. Residents indicated they trust the Fletcher House staff and would feel comfortable reporting abuse to them at any time. The residents demonstrated understanding that the facility has appropriate medical and victim advocacy networks in place. They affirmed that they felt safe and cared for in the facility. Staff and resident interactions were observed by the Auditor and appeared respectful and positive.

Number of Standards Exceeded: 0

Number of Standards Met: 43

- §115.311; §115.312; §115.313; §115.315; §115.316; §115.317; §115.318
- §115.321; §115.322
- §115.331; §115.332; §115.333; §115.334; §115.335
- §115.341; §115.342
- §115.351; §115.352; §115.353; §115.354
- §115.361; §115.362; §115.363; §115.364; §115.365; §115.366; §115.367; §115.368
- §115.371; §115.372; §115.373; §115.376; §115.377; §115.378
- §115.381; §115.382; §115.383; §115.386; §115.377; §115.388; §115.389
- §115.401; §115.403

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

Concern #1- There was a blind spot in the prayer room located on the second floor.

Corrective Action: A digital video camera was installed into the current video monitoring system. The blind spot is now monitored by the Control Center.

PREVENTION PLANNING

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

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

115.211 (a)

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

115.211 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Intake Pre-Audit Questionnaire
2. Policy 700.40 Sexual Abuse and Harassment
3. Policy 700.12 Employee Training
4. Employee PREA training Curriculum and Sign-in sheets
5. Employee Handbook
6. 2018 Corporate Organizational Chart
7. Interviews with the following:
    a. Agency PREA Coordinator

b. Program Director

Findings:

The agency's zero tolerance policy against sexual abuse was clearly established in the above documentation and via interviews. The policy also outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment allegations. The Program Director (PD) serves as the PREA Compliance Manager (PCM) for the facility. The PCM reports to the Agency PREA Coordinator (APC) at the corporate level. The facility policies outline a zero tolerance policy for all forms of sexual abuse and sexual harassment. Policy requires residents to be informed about the zero tolerance policy and the PREA program during in-processing and residents are required to view a video during admission and orientation presentations. Additional program information is contained in the Resident Handbook and is posted throughout the facility as observed during the tour. The Auditor observed that PREA information, including written materials and videos, are available in English and Spanish. Additional interpretive services are available through language translation service for residents who do not speak or read English or Spanish. Records indicate that all employees received initial training and will receive annual training in the future.

Corrective action: None required

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

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

115.212 (a)

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

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if

the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The facility does not contract with other facilities for the confinement of its residents.

Corrective action: None required

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

1. Intake Pre-Audit Questionnaire
2. Policy 700.40 Sexual Abuse and Harassment
3. Facility Staffing Plan
4. Interviews with the following:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. Agency PREA Coordinator

Findings:

The policies require Fletcher House to review their staffing plans on an annual basis. A review of the staffing plan and an interview with the PD support compliance with this PREA standard. The PD acknowledged that when developing the annual staffing plan, each element of the standard is carefully considered. With Policy 700.40 as a guide, administration considers safety and security issues when they review their staffing plan. According to policy, Fletcher House adheres to minimum staffing ratios of 1:8 during awake hours and 1:16 during sleep hours. Based on interviews with administrative staff, the agency has provided all necessary resources to implement programs and procedures to ensure compliance with PREA standards. The audit included an examination of all video monitoring systems, resident access to telephones, and rosters. Video cameras with monitoring capabilities are visible throughout the facility and observed by the Auditor. The Auditor observed cameras being monitored by the PD as well as by staff in a locked Control Center. Additionally, documentation of unannounced rounds covering all shifts by administrative staff was reviewed. Policy prohibits staff from alerting other staff members that supervisory rounds are occurring and interviews with staff confirmed unannounced rounds to all areas of the institution are conducted on a weekly basis.

Corrective action: None required

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents) ☐ Yes ☐ No ☒ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) ☐ Yes ☐ No ☒ NA

115.215 (c)

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

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

115.215 (d)

- Does the facility implement policies and 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 an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

115.215 (e)

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

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

115.215 (f)

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

- 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.

1. Fletcher House Pre-Audit Questionnaire
2. Policy 200.08 Contraband and Client Searches
3. Policy 200.02 Staffing
4. Contraband List
5. Contraband Seizure Form (B)
6. PREA Training (Power Point Presentation)
7. PREA Employee training sign-in sheets
8. Interviews:
    a. Random staff
    b. Residents

Findings:

Policy 200.02 establishes that cross-gender strip and/or cross-gender body cavity searches are prohibited, except in emergency situations or when performed and documented by a medical practitioner. Staff indicated they received cross-gender pat search training during initial training. Each unit has individual shower stalls, as observed by the Auditor. The facility has implemented a policy that all staff working the unit will announce themselves prior to walking onto the unit to allow residents the opportunity to prepare themselves from a privacy perspective. The residents interviewed acknowledged they are able to shower, dress, and use the toilet privately, without being viewed by staff of the opposite gender.

Staff were aware of the policy prohibiting the search of transgender or intersex residents for the sole purpose of determining the resident's genital status. Resident interviews revealed that during the auditing period, there were no exigent circumstances requiring cross-gender viewing of a resident by a staff member.

Corrective action: None required

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

1. Fletcher House Pre-Audit Questionnaire

2. Policy 300.04 Rights of Clients
3. Document: Clients Rights (signed by residents of the facility)
4. Resident Handbook (English and Spanish)
5. Interviews:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. PREA Coordinator
    c. Random staff

Findings:

Policy 300.04, the Resident Handbook (English and Spanish), and staff interviews address the components of this standard. Based on policy review, interviews, and observations made by the Auditor, Fletcher House takes appropriate steps to ensure residents with disabilities and residents who are LEP have an opportunity to participate in and benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. PREA handouts, bulletin board postings, and resident handbooks are in both English and Spanish. These documents were also reviewed by the auditor. The translation service, Language Access Coordinators, is provided for residents who do not have a basic command of the English language. There were no residents identified as LEP at the time of this audit.

Corrective action: None required

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in

the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

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

115.217 (b)

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

- Unless prohibited by law, 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.06 Employee Selection
3. Background checks documentation for NJDOC
4. Background checks documentation from HireRight
5. Volunteers of America, Application for Employment
7. Interviews:
    a. Vice President of Program Operations and Human Resources Administration

Findings:

A review of the above documentation, including a random sampling of employee background checks, and an interview with the Vice President of Program Operations and Human Resources Administration support compliance with this standard. The review of this documentation reveals that the agency makes its best efforts to contact all prior employers for information on substantiated allegations of sexual abuse or resignations which occurred during

a pending investigation of sexual abuse. Submission of false information by any applicant is grounds for termination, as defined in the Application for Employment. Per policy, the agency also provides information on substantiated allegations of sexual abuse/sexual harassment on a former employee, when requested from an employer for whom such employee has applied to work, unless prohibited by law. The Vice President of Program Operations and Human Resources Administration confirmed that appropriate licensing and certifying agencies are notified when professional staff are terminated for substantiated allegations of sexual abuse/sexual harassment.

Corrective action: None required

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 100.05 Physical Plant

1. Interviews:
   a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

The facility has not made any substantial expansions or modifications to existing facilities. The video monitoring technology was updated to address the prayer room blind spot discovered by the Auditor during the on-site visit.

Corrective action: Additional camera installed in Fletcher House prayer room.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Policy 400.07 Access to Medical/Dental Services
4. MOU with Services Empowering Rights of Victims (SERV) Center for Family Services
5. Interviews:
    a. Nurse Manager, Our Lady of Lourdes Hospital Emergency Department
    b. Program Director, Services Empowering Rights of Victims (SERV) Center for Family Services
    c. Random staff

Findings:

A review of policies, staff interviews, telephone interviews with representatives of Our Lady of Lourdes Hospital and SERV were conducted regarding this standard. Staff were knowledgeable of the procedures required to secure and obtain usable physical evidence, when sexual abuse is alleged. Staff were aware NJDOC and CPD conducts investigations regarding sexual abuse/harassment allegations. The facility utilizes Our Lady of Lourdes Hospital located in Camden, New Jersey for forensic medical examinations, that are conducted by a SANE. Additionally, there is a MOU between Fletcher House and SERV for confidential support services related to an incident of sexual abuse. In addition, NJDOC mental health staff are available to accompany and support a resident victim through the forensic medical

examination and the investigatory process, as per Policy 400.07. These services are at no cost to the resident. There were no forensic examinations conducted during the auditing period.

Corrective action: None required

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No
- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

1. Fletcher house Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Interviews:
    a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

Policy 700.33 states, "All allegations of sexual abuse from clients are reported to local law enforcement (CDP) as well as the NJDOC Office of Community Programs and the NJDOC SID." There were no allegations of a PREA related incident during the auditing period.

Corrective action: None required

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

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

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

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

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

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

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

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

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.12 Continuous Training
3. PREA Training (Power Point Presentation)
4. PREA Employee training sign-in sheets
5. Interviews:
    a. Random staff

Findings:

A review of the Fletcher House policies and the PREA training curriculum was conducted by the Auditor and found to be comprehensive. Staff indicated that they received the required PREA training during orientation and that they understood the zero tolerance policy as well as their roles and responsibilities. The training is also provided annually. The training records support the finding that all staff received comprehensive PREA training.

Corrective action: None required

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.24 Volunteer Services
3. PREA training records

Findings:

All volunteer training records reviewed demonstrated that contractors and volunteers are trained in PREA policy. At the time of the audit, the facility only had one volunteer who was an intern with unit management and no contractors that have direct contact with residents. The volunteer are required to read, understand, and confirm receipt of the Agency's zero tolerance policy. There were no contractors at the facility at the time of the on-site visit.

Corrective action: None required

Standard 115.233: Resident education

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

115.233 (a)

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

115.233 (b)

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

115.233 (c)

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

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 300.04 Rights of the Client
3. Document: Clients Rights
4. Resident Acknowledgement of Receipt (Resident Handbook)
5. Orientation Checklist
6. PREA Training (Power Point Presentation)
7. Interviews:
    a. Residents (16 residents, 21% of resident population)

Findings:

The Orientation Checklist revealed that residents received PREA information contained in the resident orientation packet, in addition to information provided by the case worker, as required by policy. Intake packets were reviewed for compliance. Residents watch an online PREA video (https://ytube/kEFgjDvzBRc). The Auditor observed posters in the housing units and throughout the facility which include the PREA phone number to confidentially report an incident. During the interviews, residents indicated they received information about the facility's rules against sexual harassment/abuse. They also indicated they were advised about

their right not to be sexually harassed/abused, their right not be punished for reporting sexual abuse/harassment, and how to report sexual abuse/harassment. Residents were also aware of services outside of the facility in the event they are involved in a PREA related incident.

Corrective action: None required

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators 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 115.221(a).] ☒ Yes ☐ No ☐ NA

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Investigation Packet
5. Interviews:
    a. Random staff
    b. Interview with NJDOC representative

Findings:

All criminal investigations are conducted by the NJDOC and/or the CPD. Policy 700.33 states, "The facility shall report all allegations of sexual abuse and harassment including third party and anonymous reports to the NJDOC." Program staff are required to fully cooperate with any investigation regarding a PREA allegation. Since the facility had no allegations of sexual abuse/harassment during the auditing period, there were no investigative packets to review.

Corrective action: None required

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

115.235 (b)

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

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?
  ☐ Yes ☒ No

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.]
  ☐ 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

Interviews:

a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

The facility does not employ medical or mental health staff. All residents receive medical or mental health treatment through the local Emergency Department at Our Lady of Lourdes Hospital located in Camden, NJ. Mental health treatment through the community is available through SERV, or by referral back to the NJDOC.

Corrective action: None required

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

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

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

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

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

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

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

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

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

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

115.241 (e)

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

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

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

115.241 (f)

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

115.241 (g)

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

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

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

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.37 Intake
3. Review of SecurManage software program
4. Review of signed information at intake from the Resident
5. Review of Vulnerability Assessment Instrument: Volunteers of America Delaware Valley, Behavioral Health & Reentry Services, PREA Screening Checklist
6. Interviews:
    a. Treatment Coordinator
    b. Program Assistant

Findings:

Per Policy 700.37, residents are assessed within 72 hours of their arrival for vulnerability. Interviews with the Treatment Coordinator and Program Assistant verified that there is a thorough system for collecting information and providing continued re-assessment and follow-up services as needed. All residents are accessed prior to arriving at Fletcher House and ordinarily, staff conduct assessments within 24 hours of the resident's arrival again. This process was confirmed by a review of forms and interviews with staff and residents.

Corrective action: None required

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing:

lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.37 Intake
3. Review of SecurManage software program
4. Review of intake information signed by residents
5. Review of Vulnerability Assessment Instrument: Volunteers of America Delaware Valley, Behavioral Health & Reentry Services, PREA Screening Checklist
6. Interviews:
    a. Treatment Coordinator
    b. Program Assistant
    c. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

Policies require the use of a screening instrument (reviewed by auditor) to determine the appropriate housing, bed assignment, work assignment, education, and other program assignments, with the goal of keeping residents at high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. All residents are screened within 72 hours of arrival at the facility per policy. A review of the documents associated with these procedures indicates the information from the risk screening is used to ensure the safety of each resident. Documentation and interviews confirmed that housing and programming assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification. The facility does not use isolation type housing for residents at risk of sexual victimization. The Program Director (PD)/PREA Compliance Manager (PCM) indicated that should this situation arise, the resident will be transferred to another living unit or facility to ensure their safety.

Corrective action: None required

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

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

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

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

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1.Fletcher House Pre-Audit Questionnaire
2. Policy 600.09 Client Grievance Procedure
3. Policy 700.12 Continuous Training
4. Policy 300.04 Rights of the Clients
5. Employee Handbook
6. Resident Handbook
7. Fletcher House Grievance Form (Formal Grievance Form)
8. Interviews:
    a. Random staff
    b. Residents (21% of population)

Findings:

Documentation as well as staff and resident interviews revealed the multiple ways (verbally, in writing, anonymously, privately, and third party) residents can report sexual harassment/abuse, retaliation for reporting sexual abuse and sexual harassment, and staff neglect/violation of responsibilities which may be contributory to such incidents. A review of procedures indicated

to the auditor that Fletcher House has procedures in place for staff to privately report sexual abuse and sexual harassment of residents. There are posters and other documents in English and Spanish on display throughout the institution (observed by auditor) that explain reporting methods.

Corrective action: None required

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 600.09 Client Grievance Procedure
3. Policy 700.12 Continuous Training
4. Policy 300.04 Rights of the Clients
5. Employee Handbook
6. Resident Handbook
7. Fletcher House Statement of Grievance (Formal Grievance Form)
8. Interviews:
    a. Random staff
    b. Residents (21% of population)

Findings:

A review of documentation and interviews revealed that staff and residents alike were aware of the multiple ways (verbally, in writing, anonymously, privately, and third party) for residents to report sexual harassment/abuse. According to policy 600.09, "Clients experiencing problems with the program may seek resolution in an equitable, non-punitive manner and with no adverse repercussions to the client and/or his/her status in the Community Release Program." The auditor's review revealed that Fletcher House has procedures in place for staff to privately report sexual abuse and sexual harassment of residents. There are posters and other documents in English and Spanish on display throughout the institution (observed by auditor) that explain reporting methods.

Corrective action: None required

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 400.13 Mental Health and Support Services
6. MOU with SERV
7. Publication, "You Have the Right to be Safe from Sexual Violence"
8. Interviews:
    a. Program Director, SERV
    b. Program Director

Findings:

Per the MOU with SERV, residents have access to outside confidential support services while housed at the facility. Residents in the program who are identified by the NJDOC as having special mental health needs are placed on a Special Needs Roster. Residents on the Special Needs Roster are required to go to the regional institution monthly for medication checks. The SERV telephone number is available to all residents and is posted in the units and throughout the facility allowing residents immediate confidential support services. PREA postings with the Ombudsman, PREA hotline, and SERV telephone numbers are visible on the walls throughout the facility.

Corrective action: None required

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.40 Sexual Abuse and Harassment
3. Volunteers of America Delaware Valley https://voadv.org/PREA
5. Interviews:
    a. Random staff

Findings:

The Auditor observed third-party reporting information posted throughout the facility. The information included toll-free numbers, mailing addresses, and other reporting options. The information is also included in the resident orientation packet. Residents indicated in interviews that they were aware of the different methods to report. Information is also listed on the Volunteers of America Delaware Valley website at: www.voadv.org.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

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

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

115.261 (b)

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

115.261 (c)

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

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

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Interviews:
    a. Random staff
    b. Program Director
    c. Residents

Findings:

Per policy, staff can report verbally, in writing, and anonymously any incidents of sexual harassment/assault. Posted notices assist a third party to report any allegation of sexual harassment/abuse. The staff and residents interviewed indicated they were aware of third party reporting. Residents responded that they would feel more comfortable reporting an incident of sexual harassment/abuse to a staff member at the facility. The auditor observed reporting telephone numbers and addresses posted in the visitation area. The auditor tested the posted numbers to ensure they were accurate.

Corrective action: None required

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 600.10 Client Rights
3. Interviews with the following:
    a. Random staff
    b. Program Director

Findings:

Staff were well aware of their duties and responsibilities. They also indicated they would act immediately to protect the resident, to include, if necessary, separating the alleged victim and perpetrator, securing the scene to protect potential evidence, not allowing residents to destroy potential evidence, and contacting the shift supervisor. In this auditing period, there were no instances in which staff determined that a resident was subject to substantial risk of imminent sexual abuse. During the interview, the PD indicated that if a resident was at risk of sexual victimization, he could temporarily be placed in another unit or moved to another facility. The facility does not use isolation for alternate placement.

Corrective action: None required

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Policy 700.40 Sexual Abuse and Harassment
4. Interviews:
    a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

Upon receiving an allegation that a resident was sexually abused while confined at another facility, Fletcher House must notify the other facility within 72 hours as verified by the PD. Investigations are conducted by the CPD or the NJDOC SID. Policy requires that all incident reports be completed before the end of the employees shift. Staff indicated that they would complete an incident report immediately. The facility did not receive any allegation of sexual abuse or harassment from another facility during the auditing period.

Corrective action: None required

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

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

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

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 300.06 Sexual Misconduct and Inappropriate Behavior
3. Policy 700.40 Sexual Abuse and Harassment
7. Policy 700.12 Continuous Training
8. PREA Training (Power Point Presentation)
9. PREA Employee training sign-in sheets
10. Interviews:
    a. Random staff
    b. Shift Manager
    c. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

All staff interviewed were very knowledgeable concerning their first responder duties and responsibilities when learning of an allegation of sexual abuse or sexual harassment. Staff indicated they would separate the residents, secure the scene, not allow residents to destroy potential evidence, and contact the Shift Manager. In this auditing period, there were no allegations that a resident was sexually abused and the first responder was required to separate the victim and alleged perpetrator. The Auditor verified this through interviews with the Program Director, random staff, the Shift Manager, and an examination of pertinent policies and training documentation.

Corrective action: None required

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Policy 300.06 Sexual Misconduct and Inappropriate Behavior
4. Interviews:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. Random staff

Findings:

Policy requires staff receiving a report of a sexual assault or attempted sexual assault, or becoming aware of sexual activity between residents or between a resident and staff, visitor, volunteer to immediately report this event to a supervisor. The supervisor has the responsibility to immediately report the incident to the PD, PREA Coordinator, and to follow procedures outlined in Policy 300.06 which mandates the incident must be reported to the NJDOC and the CPD immediately.

Corrective action: None required

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

Interviews with the following:
a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

Fletcher house is a non-union facility.

Corrective action: None required

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Policy 700.40 Sexual Abuse and Harassment
4. Volunteers of America Delaware Valley Retaliation Monitoring/Tracking Log (115.67)
3. Interviews:
    a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

The PREA Coordinator is required to monitor retaliation. Program Director (PD)/PREA Compliance Manager (PCM)and the PREA Coordinator were interviewed concerning this standard. Policy 700.40 requires residents and staff who have reported sexual misconduct shall be provided protection against retaliation. Policy 700.40 also provides procedures to make housing changes and/or remove the alleged staff or resident from contact with victim to ensure the victim's safety. The policy also directs staff to provide emotional support services for residents or staff that fear retaliation for reporting or cooperating with investigations. The PREA Coordinator indicated that she reviews the conduct or treatment of any resident or staff who reported sexual misconduct as well as the victims to determine if retaliation is occurring. Monitoring is conducted at a minimum of 90 days and continues as needed. Items monitored by the PREA Coordinator include resident disciplinary reports, status checks, housing or program changes, negative performance review, or reassignment of staff. These documents were reviewed by the Auditor.

Corrective action: None required

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

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

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

115.271 (b)

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

115.271 (c)

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

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

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

115.271 (d)

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

115.271 (e)

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

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

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Policy 300.06 Sexual Misconduct and Inappropriate Behavior

4. Interviews:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. PREA Coordinator

Findings:

Policy 700.33 states, "All allegations of sexual abuse from clients are reported to local law enforcement (CDP) as well as the NJDOC Office of Community Programs and the NJDOC SID." There were no allegations of a PREA related incident during the auditing period. The PREA Coordinator is responsible for reporting the allegations to the appropriate authorities.

Corrective action: None required

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.40 Sexual Abuse and Harassment
3. Policy 300.06 Sexual Misconduct and Inappropriate Behavior

3. Interviews:
    a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

According to an interview with the PD and the PREA Coordinator, the evidence standard is a preponderance (51%) of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. This was confirmed with interviews with the NJDOC staff responsible for investigations. The Fletcher House does not conduct any investigations.

Corrective action: None required

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

1. Fletcher house Pre-Audit Questionnaire
2. Policy 600.09 Client Grievance Procedure
3. Policy 700.33 Investigations
4. Interviews:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. PREA Coordinator

Findings:

During the auditing period, there were no allegations of sexual abuse. When an allegation is made, the residents involved are removed from the facility/ program pending the outcome of the investigation. In an interview with the PREA Coordinator once a resident is removed from the program they are returned to a NJDOC facility. In the event the resident returns to Fletcher House, the outcome of the investigation would be communicated to the resident. All investigations require a written response, including the rationale for the decision, provided to the resident. Copies of all allegation decisions will be maintained.

Corrective action: None required

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 300.06 Sexual Misconduct and Inappropriate Behavior
3. Policy 3-3 Personnel
4. Policy 3-9 Standards of Conduct
5. Notice of Caution (NOC)
6. Code Ethics
7. Performance Improvement Plan (PIP)
8. Interviews with the following:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. PREA Coordinator

Findings:

The PD confirmed that staff are subject to disciplinary sanctions for violating agency sexual abuse and/or sexual harassment policies. There were no allegations of residents engaging in sexual activity with staff during the auditing period. The disciplinary sanctions for rule violations are explained by Human Resources at orientation. An interview with the Program Director (PD)/PREA Compliance Manager (PCM) revealed that employee rules and sanctions are available to all employees through the facility intranet.

Corrective action: None required

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

1. Fletcher House Pre-Audit Questionnaire
2. Policy 300.06 Sexual Misconduct and Inappropriate Behavior
3. Interviews with the following:
    a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

Policy 300.06 holds volunteers to the same expectations as the employees, relative to contact with residents. Volunteers receive the same zero tolerance for sexual abuse/harassment policy as employees of the facility and must read, understand, and sign the Confirmation of Receipt document. All of the Confirmation of Receipt documentation was reviewed by the Auditor. The PD verified that any service contract will be terminated upon a finding of resident sexual harassment/sexual abuse by a contractor or volunteer. There have been no incidents during the auditing period. The Program Director (PD)/PREA Compliance Manager (PCM) confirmed that all contractors are escorted by Fletcher House staff.

Corrective action: None required

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

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

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

- 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 600.11 Client Discipline
3. Resident Handbook
4. Interviews with the following:
    a. Random staff
    b. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

According to the Program Director (PD)/PREA Compliance Manager (PCM), there were no administrative findings of resident-on-resident sexual harassment/abuse that occurred at the facility. There were zero allegations of staff and residents engaging in sexual activity during the auditing period. This policy ensures residents are treated fairly under a consistent system of discipline that teaches and encourages appropriate behaviors and discourages inappropriate behaviors. In addition, appropriate measures must be taken to protect the due process rights of residents who are, or who may be, subject to discipline. The orientation packet, which includes the Resident Handbook addresses all disciplinary sanctions for residents. These materials are part of the new resident orientation and were reviewed by the Auditor.

Corrective action: None required

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher Pre-Audit Questionnaire
2. Policy 400.07 Access to Medical/Dental Services
3. Local Hospital Admission Fact Sheet
4. Notification of Emergency Room Visit (B)
5. Special Incident Report (C)
6. Interviews with the following:
    a. PREA Coordinator
    b. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

Interviews with the PD and the PREA Coordinator confirm the facility can receive medical and mental health information and has the capacity to provide continued reassessment and follow

up services. According to documentation and interviews, screening has not resulted in any disclosures of prior victimization or perpetrated sexual abuse. Procedures are in place to offer follow up medical and mental health treatment if the staff become aware of such abuse or perpetrated abuse. Interviews confirmed that treatment services are offered without financial cost to the resident. Policy states that residents requiring treatment to meet with medical and mental health practitioners and that treatment plans must be based on the resident's assessed risk. Policy establishes that the treatment needs of residents are identified and prioritized and is kept in the resident permanent treatment file. There had been no victims or perpetrators identified at the time of the on-site visit, therefore no files were reviewed.

Corrective action: None required

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

1. Fletcher House Pre-Audit Questionnaire
2. Policy 400.07 Access to Medical/Dental Services
3. Document: VOADV QA Complaint Form
4. MOU with SERV
5.. Interviews with the following:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. SANE/SAFE Nurse Manager, Our Lady of Lourdes Hospital
    c. Program Director, SERV

Findings:

According to policy, the facility provides timely, unimpeded access to emergency medical and crisis intervention services at no cost to the resident. Referrals are made to SERV and Our

Lady of Lourdes Hospital. Interviews indicate there have been no incidents requiring these services during the auditing period.

Corrective action: None required

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

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

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.33 Investigations
3. Interviews with the following:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. Assistant Program Director (member of Incident Review Team)

Findings:

In the event of an PREA incident, the Incident Review Team reviews each occurrence for cause, staffing, and physical barriers. The team makes recommendations for prevention and implementation of remedy(s). The facility incident review team consists of the Program Director (PD)/PREA Compliance Manager (PCM), Assistant Program Director, The PREA Coordinator, and the Treatment Director. Interviews with two of the Incident Review team (Program Director, Assistant Program Director indicate that all incidents are reviewed and documented.

Corrective action: None required

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.34 Data Collection
3. Volunteers of America Delaware Valley PREA Annual Report 2017
4. Interviews with the following:
    a. Program Director (PD)/PREA Compliance Manager (PCM)
    b. PREA Coordinator

Findings:

Policy 700.34 mandates that the survey data includes the information necessary to answer all questions from the most recent version of the Survey of Sexual Violence, conducted by the Department of Justice. The agency aggregates and reviews all data annually. The previous year's annual report was reviewed by the auditor on the Volunteers of America Delaware Valley website. (www.voadv.org/pdf_files/2017-annual-prea-report).

Corrective action: None required

Standard 115.288: Data review for corrective action

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

115.288 (a)

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

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

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

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.34 Data Collection
3. Volunteers of America Delaware Valley Corporate PREA Report 2017
4. Document: Research Proposal Format
5. Document:
4. Interviews with the following:
    a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

In accordance with Policy 700.34, the facility reviews data collected and aggregated in order to improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. The report includes comparisons of the current year's data and corrective actions with those from prior years and will provide an assessment of the agency's progress in addressing sexual abuse. The report is approved by the Program Director (PD)/PREA Compliance Manager (PCM) and made available to the public through Volunteers of America Delaware Valley website at www.voadv.org/pdf_files/2017-annual-prea-report. The facility redacts specific information when it could present a clear and specific threat to the safety and security of the facility. The facility states the nature of the material redacted and all personal identifiers are removed. Documentation was posted on the website and viewed by the Auditor.

Corrective action: None required

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

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

115.289 (b)

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

115.289 (c)

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

115.289 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. Fletcher House Pre-Audit Questionnaire
2. Policy 700.34 Data Collection
3. Volunteers of America Delaware Valley Corporate PREA Report 2017
4. Interviews with the following:
    a. Program Director (PD)/PREA Compliance Manager (PCM)

Findings:

Policy 700.34 Data Collection states, "Data generated from research projects shall be confidential and accessible only to those persons indicated on the signed release of information form." In publication of data generated, all names of participants shall be kept strictly confidential. In instances related to sexual abuse, the data will be made publicly available after all personal identifiers are removed. Records shall be retained in accordance with state law, rule, and department policy. The Program Director confirmed that all data is secured on password protected, encrypted electronic media or in locked file cabinets.

Corrective action: None 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 inmates, residents, and detainees? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

The auditor was allowed access to all areas of the facility. The auditor was able to conduct private interviews with both residents and staff. The auditor was provided supporting documentation before and during the audit. Notifications of the audit posted throughout the facility allowed residents to send confidential letters to the auditor prior to the audit. There were no confidential correspondence received by the auditor.

Corrective action: None 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 within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

Findings:

Fletcher House has fully implemented all policies, practices, and procedures outlined in the PREA standards. The auditor reviewed applicable standards and through the review of support documentation, interviews with staff and residents, and the observation of physical evidence, concluded that this facility fully meets and substantially complies with the PREA standards for the relevant audit period. Facility policies are directly tied to the PREA standards and staff expectations. The facility's leadership is fully committed to eliminating sexual abuse/sexual harassment, as evidenced in the realistic staffing analysis and the recommendations for enhanced supervision techniques. PREA training for staff and residents is documented and all stakeholders receive the appropriate level of training and are knowledgeable of the intent of the PREA and the tools available to ensure prevention, detection, reporting and response to sexual abuse incidents. Sexual abuse and victimization propensity screening is well established and tracked in an organized fashion. Referrals for mental health counseling are integrated in the intake and allegations of sexual abuse processes. Medical networks for the residents are established in the community. The public has access to reporting mechanisms and facility PREA trends data via their website at http://www.voadv.org/prea

The facility currently meets all applicable PREA standards and no corrective actions are required.

Corrective action: None 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.

James L. Roland, Jr. October 4, 2018

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.