



**POLICY STATEMENT**  
Commonwealth of Pennsylvania • Department of Corrections

<b>Policy Subject:</b> <b>Inspections and Audits</b>		<b>Policy Number:</b> <b>1.1.2</b>
<b>Date of Issue:</b> <b>March 16, 2018</b>	<b>Authority:</b> <b>Signature on File</b> <b>John E. Wetzel</b>	<b>Effective Date:</b> <b>March 23, 2018</b>

**I. AUTHORITY**

The Authority of the Secretary of Corrections to direct the operation of the Department of Corrections is established by Sections 201, 206, 506, and 901-B of the Administrative Code of 1929, 71 P.S. §§61, 66, 186, and 310-1, Act of April 9, 1929, P.L. 177, No. 175, as amended.

**II. APPLICABILITY**

This policy is applicable to all facilities operated under the jurisdiction of, or conducting business with the Department of Corrections, Department employees, volunteers, contract personnel, visitors, and inmates.

**III. POLICY**

It is the policy of the Department that each facility shall incorporate into its goals and objectives the achievement and maintenance of American Correctional Association (ACA) accredited status and that an annual inspection or review to evaluate continued compliance with policy and ACA standards is completed at each facility.<sup>1</sup>

**IV. PROCEDURES**

All applicable procedures are contained in the procedures manual that accompanies this policy document.

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<sup>1</sup> 4-4410

## **V. SUSPENSION DURING AN EMERGENCY**

In an emergency or extended disruption of normal facility operation, the Secretary/designee may suspend any provision or section of this policy for a specific period.

## **VI. RIGHTS UNDER THIS POLICY**

This policy does not create rights in any person nor should it be interpreted or applied in such a manner as to abridge the rights of any individual. This policy should be interpreted to have sufficient flexibility to be consistent with law and to permit the accomplishment of the purpose(s) of the policies of the Department of Corrections.

## **VII. RELEASE OF INFORMATION AND DISSEMINATION OF POLICY**

### **A. Release of Information**

#### 1. Policy

This policy document is public information and may be released upon request.

#### 2. Confidential Procedures (if applicable)

Confidential procedures for this document, if any, are not public information and may not be released in its entirety or in part, without the approval of the Secretary of Corrections/designee. Confidential procedures may be released to any Department of Corrections employee on an as-needed basis.

### **B. Distribution of Policy**

#### 1. General Distribution

The Department of Corrections policy and procedures shall be distributed to the members of the Central Office Executive Staff, all Facility Managers, and Community Corrections Regional Directors on a routine basis. Distribution of confidential procedures to other individuals and/or agencies is subject to the approval of the Secretary of Corrections/designee.

#### 2. Distribution to Staff

It is the responsibility of those individuals receiving policies and procedures, as indicated in the "General Distribution" section above, to ensure that each employee expected or required to perform the necessary procedures/duties is issued a copy of the policy and procedures either in hard copy or via email, whichever is most appropriate.

## VIII. SUPERSEDED POLICY AND CROSS REFERENCE

### A. Superseded Policy

#### 1. Department Policy

1.1.2, Inspections and Audits, issued July 18, 2016, by Secretary John Wetzel.

#### 2. Facility Policy and Procedures

This document supersedes all facility policy and procedures on this subject.

### B. Cross Reference(s)

#### 1. Administrative Manuals

a. 1.1.1, Policy Management System

b. 8.3.1, Community Corrections Security

c. 9.1.1, Correctional Industries

#### 2. ACA Standards

a. Adult Correctional Institutions: 4-4017, 4-4075, 4-4107, 4-4151, 4-4152, 4-4211, 4-4221, 4-4321, 4-4329, 4-4410, 4-4423, 4-4424, 4-4430, 4-4455, 4-4464

b. Correctional Training Academies: 1-CTA-2A-01, 1-CTA-2A-02, 1-CTA-3E-01, 1-CTA-3D-02

#### 3. PREA Standards

115.401, 115.402, 115.403, 115.404, 115.405



**PROCEDURES MANUAL**  
Commonwealth of Pennsylvania • Department of Corrections

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Release of Information:

**Policy Document:** This policy document is public information and may be released upon request.

**Procedures Manual:** The procedures manual for this policy may be released in its entirety or in part, with the prior approval of the Secretary/designee. Unless prior approval of the Secretary/designee has been obtained, this manual or parts thereof may be released to any Department employee on an as needed basis only.

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## Section 1 – Annual Operations Inspections

### A. Scope of the Audit<sup>1</sup>

An annual inspection will encompass compliance with Department policies, applicable laws, procedures, practices, and related professional standards.<sup>2</sup> The areas to be inspected are listed below by the Bureau that **is responsible for** conducting the inspection. Some of the areas may not be applicable to all facilities.

#### 1. Bureau of Standards, Audits, and Accreditation

Facilities will conduct an internal Policy Compliance Review to be completed annually by the Corrections Superintendent's Assistant (CSA).

**NOTE:** A Policy Compliance Review is not required when an American Correctional Association (ACA) audit is conducted in the same calendar year.

#### 2. Office of Population Management

Inmate Records

#### 3. Central Office Security Division

An external security audit/inspection will be completed every two years. This audit/inspection will take place during the year that the facility is not scheduled for an External Security Analysis (SA) or Vulnerability Assessment (VA).

#### 4. Bureau of Operations

Maintenance	Construction
Capital Projects <sup>3</sup>	Environmental Issues
Fire, Safety, Sanitation <sup>4</sup>	

#### 5. Bureau of Health Care Services<sup>5</sup>

Medical Services<sup>6</sup>  
Food Service<sup>7</sup>  
Psychiatric Services (in conjunction with the Psychology Office)

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<sup>1</sup> 4-4410

<sup>2</sup> 4-4017, 4-4107, 4-4423, 4-4455

<sup>3</sup> 1-CTA-2A-01

<sup>4</sup> 4-4151, 4-4152, 4-4211, 4-4221, 4-4321, 4-4329, 4-4410, 4-4455, 1-CTA-2A-02, 1-CTA-3E-01

<sup>5</sup> 4-4423, 4-4424

<sup>6</sup> 4-4423

<sup>7</sup> 1-CTA-3D-02, 4-4329

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6. Psychology Office

Psychology Services  
Psychiatric Services (in conjunction with the Bureau of Health Care Services)

7. Bureau of Human Resources

Human Resource offices are subject to the Office of Administration’s Personnel Management Reviews.

8. Bureau of Administration

The Department’s Fiscal Services and Facility Business Offices are subject to review by the Department of the Auditor General; **or internal fiscal related audits as determined by Central Office.**

9. Bureau of Treatment Services<sup>8</sup>

Counseling Services	Volunteer Programs
Alcohol & Other Drug Programs	Religious Activities
PACT/Case Management	Recreational Activities
Inmate Employment	Transitional Housing Unit (THU)/Veterans Service Unit (VSU) (in conjunction with Bureau of Community Corrections [BCC])

10. Bureau of Corrections Education<sup>9</sup>

Barber School/Shop	Cosmetology
Education/Voc-Ed	Library

11. Staff Development and Training

Staff Training<sup>10</sup>

12. Correctional Industries<sup>11</sup>

In accordance with Department policy **9.1.1, “Correctional Industries,”** all Correctional Industries (CI) shops will ensure that all required safety and environmental standards are met. CI operations are subject to an independent financial review by the Department of the Auditor General **or internal fiscal related audits as determined by Central Office.**

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<sup>8</sup> 4-4017, 4-4107, 4-4430

<sup>9</sup> 4-4455, 4-4464

<sup>10</sup> 4-4075

<sup>11</sup> 4-4455

## **B. Inspection Process<sup>12</sup>**

1. The inspections of all functional areas identified in **Subsection A. above** will be conducted annually.
2. The inspection standards and/or format for the areas to be inspected will be available in the Accreditation, Audit, & Risk Management Security (AARMS) system and in the ACA folder on SharePoint. The facility will be able to access these prior to the inspection in order to conduct a self-audit and to note any changes in the inspection format.
3. The inspectors will contact the Facility Manager/designee one month prior to the inspection to confirm the appointment time and date, schedule activities, discuss inspection issues of particular importance, and review issues related to the inspection.
4. Multiple inspection teams may conduct simultaneous inspections. Time frames for conducting each area inspection may vary with regard to differences in facility size and functions. Each Bureau Director will determine the size of the inspection team for his/her bureau.
5. Facility staff, not specifically assigned to the inspection team who are essential to the facility being inspected or are participating for training purposes, may accompany the inspection team and assist with the inspection. He/she should be briefed by the individual(s) responsible for the particular inspection concerning his/her role in the inspection process.
6. Each inspector will annotate each inspection standard to indicate when the facility is compliant, non-compliant, or if the inspection standard is non-applicable. All findings of non-compliant or non-applicable status require the inspector to enter a comment explaining why the facility was non-compliant or why the standard was non-applicable.
7. Following the inspection, an exit interview will be conducted with the Facility Manager/designee(s), where preliminary findings of the inspection will be presented and discussed. Exit interviews may be conducted with individual or multiple inspection teams.

## **C. Responsibilities<sup>13</sup>**

1. Each Facility Manager/designee shall ensure that:
  - a. appropriate facility personnel are available and able to assist the inspectors in conducting the inspection of his/her respective area(s) of responsibility;
  - b. appropriate facility department heads are notified when an email has been received from the Bureau Director/designee that inspection results have been entered in the AARMS system;

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- c. the Corrective Plans-of-Action for addressing non-compliance issues disclosed by the inspection are prepared and entered electronically in the AARMS system within 15 business days following receipt of the email from the Bureau Director/designee;
  - d. the Bureau Director/Inspection Captain/designee is notified via email that Corrective Plans-of-Action have been entered and are available to review in the AARMS system. The Regional Deputy Secretary and **CR, DOC ACA resource account** shall be copied on this notification; and
  - e. a six month progress report is submitted, when necessary, as outlined in **Subsection D. below.**
2. Each Central Office Bureau Director/designee shall ensure that:
- a. **the Bureau of Standards, Audits, and Accreditation (BSAA) is notified of the Operations inspection date via CR, DOC ACA resource account;**
  - b. appropriate staff are identified to conduct the inspections. The inspection team may include staff from facilities **with their supervisor's approval if they are selected from a facility**, other than the facility being inspected. Staff will be used in their areas of expertise;
  - c. division chiefs/designees train the inspection team members on the inspection format, criteria, reporting function, and their role in the process;
  - d. staff from his/her bureau contact the Facility Manager/designee of the facility to be inspected, coordinate the date(s) for the inspection, and notify the Facility Manager/designee who will be conducting the inspection;
  - e. each inspection is conducted in accordance with the Operations/Mock/ACA Audit Schedule **as** posted on **SharePoint**;
  - f. if for some reason a bureau cannot complete the inspection by the scheduled inspection date, they must receive a written approval from the Executive Deputy Secretary to change the date of inspection;
  - g. an email is sent to the Facility Manager/**CSA** notifying him/her that inspection results and an Executive Summary, summarizing the significant findings, have been entered and are available in the AARMS system no later than 15 working days following the audit;
  - h. facility Corrective Plans-of-Action are approved/disapproved, via the AARMS workflow process, for each standard found to be non-compliant. An email shall be sent to the Facility Manager/designee notifying him/her that Corrective Plans-of-Action approvals/disapprovals are available in the AARMS system no later than 15 working days after the Corrective Plans-of-Actions have been entered into the AARMS system by the facility; and

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- i. inspection/audit standards are reviewed annually and necessary changes are made to ensure that they are in line with current laws, policies/procedures, standards, and goals.
3. The Chief of Accreditation/designee shall:
- a. maintain the schedule for Accreditation Audits and Annual Operations Inspections on **SharePoint**;
  - b. oversee and administer the AARMS system by providing user access and passwords as well as technical assistance to auditors and facility staff in the applications of the system;
  - c. monitor and review completed Operations Inspection findings to ensure they are entered in a timely manner and report any issues of non-compliance that may have imminent and/or serious consequences to the Bureau Director/designee and the Regional Deputy Secretary;
  - d. follow up with Bureau Directors on any delinquent reports that are past the submission due dates; and
  - e. coordinate the annual review of current inspection standards by each bureau of responsibility at the end of each year to ensure ACA standards, legal mandates, policy compliance, and/or problematic issues are continually evaluated and updated.
4. The Regional Deputy Secretary shall:
- a. review all annual inspection results and Corrective Plans-of-Action for each facility in his/her region; and
  - b. review each facility's progress in resolving inspection discrepancies during the regularly scheduled quarterly facility visits.

**D. Corrective Plans-of-Action<sup>14</sup>**

1. Corrective Plans-of-Action for addressing non-compliance issues identified by the inspection are prepared and submitted electronically in the AARMS system within 15 working days as outlined in **Subsection C.1.c. above**.
2. The Bureau Director/Inspection Captain/designee **within seven business days** will review the Facility Manager's Six-Month Progress Report, if applicable, to monitor the facility's progress in correcting all noted deficiencies.
3. AARMS Corrective Plan-of-Action Workflow Options

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- a. Facility Manager/designee
  - (1) Corrective Plan-of-Action has been completed for review.
  - (2) Six-Month Progress Report has been completed for review.
- b. Central Office Bureau Director/designee
  - (1) Corrective Plan-of-Action has been ACCEPTED. No Further action is necessary.
  - (2) Corrective Plan-of-Action has been ACCEPTED. Progress Report must be submitted **as soon as possible, but no later than 45 days**.
  - (3) Corrective Plan-of-Action has NOT been accepted. See further instructions.
- c. Inspection Captain

Corrective Plan-of-Action workflow options for Inspection Captains are the same as the Central Office Bureau Director/designees workflow options in accordance with **Subsection D.3.b. above**.

**E. Bureau of Community Corrections (BCC)**

BCC Operations Inspections shall be conducted in accordance with Department policy **8.3.1, “Community Corrections Security,” Section 19**.

## Section 2 – American Correctional Association (ACA) Accreditation Process

### A. General Overview

#### 1. Scope of Accreditation

*Accreditation is a system of verification that correctional agencies comply with national corrections expected practices promulgated by committees that represent corrections professionals from all areas of the field - adult corrections and detention, juvenile corrections and detention, community corrections, probation, parole, and correctional health services.*

#### 2. **Expected Practices** Development

*The American Correctional Association (ACA) expected practices, previously referred to as standards, are the national benchmark for the effective operation of correctional systems throughout the United States and are necessary to ensure that correctional facilities are operated professionally through adherence to clear expected practices relevant to all areas/operations of the facility, including safety, security, order, inmate care, programs, justice, and administration. They also address services, programs, and operations essential to good correctional management, including administrative and fiscal controls, staff training and development, physical plant, safety and emergency procedures, sanitation, food service, and rules and discipline.*

### B. Quality Assurance and Improvement

- 1. The accreditation program is achieved through the monitoring of continuous internal reviews and inspections that evaluate the effectiveness of facility compliance with policies, procedures, and practices developed in accordance with applicable laws, ACA expected practices, and program mandates. To confirm the integrity of the internal inspection process, a quality assurance and improvement program requires independent, external assessments by representatives of the ACA that validate each facility's conformance to professional standards.*
- 2. Each Central Office Bureau of primary responsibility and each Facility Manager/designee will monitor facility operations and programs through a series of annual inspections and reviews as outlined in Section 1 of this procedures manual. These inspections and reviews shall include a review of all mandatory ACA expected practices, policy compliance, and any other expected practices as designated by the Central Office Bureau conducting the inspections.*
- 3. Each facility will be required to achieve and maintain compliance with the accreditation program in accordance with the time frames outlined in the OPS/Mock Audit/ACA Audit Schedule posted on the Department SharePoint/File Share site.*

### C. *Orientation and Training*

1. ***All Corrections Superintendent Assistants (CSAs)/designee shall be required to attend annual accreditation training as scheduled by the Central Office Director of Standards, Audits, and Accreditation. Training updates shall include ACA updates about the accreditation program and the maintenance of the electronic documentation stored in the Accreditation, Audit, and Risk Management Security (AARMS) system.***
2. ***All staff are required to participate in the accreditation program at their respective facilities, and can access the ACA Training folder posted on the SharePoint/File Share site for an understanding of the accreditation process and related reference materials.***

### D. *Program Responsibilities*

1. The ***Central Office*** Chief of Accreditation/***designee*** shall:
  - a. act as the liaison between the ***CSA/designee*** and the ACA Accreditation ***Specialist***;
  - b. maintain an internal information exchange to ensure that Department staff are provided with timely responses to inquiries about the ***expected practices*** and the process;
  - c. provide training and technical assistance related to ***expected practices*** and accreditation to field staff, as needed;
  - d. ***ensure*** the primary documentation repository ***is updated and maintained in the electronic documentation AARMS system***;
  - e. ensure that a mandatory ***ACA expected practice*** review is scheduled ***at least*** four months prior to the ***ACA*** audit during the year that a facility is scheduled ***to be*** audited;
  - f. ensure that the most current Standards Supplement including all revisions is purchased and made available to the field, in electronic format, on ***SharePoint/File Share*** and the AARMS system;
  - g. ***ensure any revisions to ACA expected practices, as outlined in the ACA Standards Supplement, are also made in the AARMS system and to the Standards Compliance Checklists for each program type posted on SharePoint/File Share***;
  - h. schedule and coordinate ACA audit ***dates*** in accordance with the contract; and
  - i. ***ensure*** AARMS usernames and passwords are assigned to the ***ACA*** Visiting Committee members ***at least two weeks prior to the audit***.

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2. The CSA/designee shall:

- a. **read and utilize as a desk reference the most current ACA Manual of Accreditation Policy and Procedure (APM-1) which can be found in the ACA folder on SharePoint/File Share on DOCNet,**

**NOTE: All forms referenced in this procedures manual, which are required to be completed by ACA, can be found in the Appendix section of the ACA Manual of Accreditation Policy and Procedures (APM-1) in the ACA folder on SharePoint/File Share.**

- b. develop a work plan that provides a structure for the facility's ongoing preparation for achieving and/or maintaining compliance with ACA **expected practices** that include the following:
- (1) the creation and maintenance of a local documentation library on the facility's local computer network;
  - (2) the assignment of **expected practices** to appropriate staff for preparation in the AARMS system;
  - (3) the **labeling, scanning, and uploading of process indicators**/secondary documentation **in the AARMS system**; and
  - (4) **the completion and uploading of all required ACA Reports in the AARMS system for each audit cycle.**
- c. ensure that a compliance maintenance system is maintained for staff to update documentation and develop local procedures, if necessary, for accreditation-related activities;
- d. ensure that an internal mock audit is conducted annually in accordance with **Subsection E.2. below**;
- e. ensure that the most current Standards Supplement containing revisions **to expected practices**, as published by ACA every two years and provided by the **Central Office** Chief of Accreditation/**designee**, is made available **electronically** to facility staff;
- f. ensure that a method for **continuous** collecting **of** data relevant to the **Significant Incident Summary (SIS)** and **Outcome Measures worksheet** is being **done and** calculated every 12 months for each year of the audit cycle;
- g. ensure the **Organization Summary for Secure Residential Facilities form** is prepared and submitted to the ACA Accreditation **Specialist** and **the CR, DOC ACA resource account** at least four to six weeks prior to the Standards Compliance Audit **on the ACA form available in the ACA folder on SharePoint/File Share**;

- h. ensure that the **Facility Narrative Summary** is prepared in accordance with **Department policy 1.1.1, “Policy Management System;”**
- i. ensure that the facility submits an **Annual Report to the ACA Accreditation Specialist and the CR, DOC ACA resource account** on the anniversary of the facility’s last panel hearing **in accordance with the ACA Annual Report form posted in the ACA folder on SharePoint/File Share; and**
- j. **ensure critical incidents that have the potential to cause the facility to become non-compliant in a mandatory expected practice for an extended period of time, are reported to the ACA Accreditation Specialist and the CR, DOC ACA resource account as soon as possible using the ACA Critical Incident Report form available in the ACA folder on SharePoint/File Share.**

## **E. Audit Preparation**

### **1. Pre-Audit Activities**

#### **a. Development of Documentation**

- (1) **Each facility shall develop the appropriate local protocol (when necessary) and process indicator documentation for each electronic standard file contained in the AARMS in accordance with the protocols listed in the ACA Standards Protocol posted in the ACA folder on SharePoint/File Share and each standard’s Self Help Key, if applicable.**
- (2) **Each facility shall ensure the documentation is uploaded into each electronic file for each year of the audit cycle.**

#### **b. Accreditation Reports**

**In addition to the documentation requirements for each ACA expected practices, the CSA/designee will ensure that the following reports available in the ACA folder in SharePoint/File Share, are completed as outlined below.**

##### **(1) Facility Narrative Summary**

- (a) The **Facility Narrative Summary** shall be completed and submitted in the proper format by December 1 of each year in accordance with Department policy 1.1.1.
- (b) The completed **Facility Narrative Summary shall** serve as the “Welcome Book” to be provided to the auditors upon the commencement of an ACA audit **which also contains the below listed reports.**

##### **i. Outcome Measures**

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- aa. Outcome Measures are quantifiable (measurable) events, occurrences, conditions, behaviors, or attitudes that demonstrate the extent to which the condition described in the corresponding performance standard has been achieved as outlined in the **Outcome Measures Technical Guidelines available in the ACA folder on SharePoint/File Share.**
  - bb. A facility undergoing an initial **Expected Practices** Compliance Audit shall have **the** 12 months of the **previous year leading up to the ACA audit** entered and calculated on the **Outcome Measures worksheet** which shall be included as part of its **Facility Narrative Summary.**
  - cc. A facility being considered for reaccreditation shall submit a completed **Outcome Measures worksheet** with the required **Annual Report** to the ACA **Accreditation Specialist** and Chief of Accreditation/**designee** for the first two years of its reaccreditation cycle. The completed third year **Outcome Measures worksheet** shall be included with the **Facility Narrative Summary** as part of the auditor's Welcome Book.
- ii. Significant Incident Summary (SIS)
    - aa. The **SIS form** requires information regarding assaults, disturbances, escapes, **sexual violence, natural disasters,** and **unnatural** deaths **to name a few.**
    - bb. A facility undergoing an initial **Expected Practices** Compliance Audit shall include the completed **SIS** as part of its **Facility Narrative Summary.**
    - cc. A facility being considered for reaccreditation shall submit a completed **SIS** with the required **Annual Report** for the first two years of its reaccreditation cycle. The completed third-year **SIS** shall be included with the **Facility Narrative Summary** as part of the auditor's Welcome Book.
- iii. Self-Evaluation Report
    - aa. The **Self-Evaluation Report is used to** document the facility's progress through the self-assessment phase of the process **and contains information showing the percentage of compliance with mandatory and non-mandatory expected practices, a list of non-applicable expected practices and reasons for such, and a list of those non-compliant and their deficiencies.** Upon completion of the report, the facility can determine if it meets the minimum threshold for achieving accreditation, which is compliance



with 100% of the mandatory **expected practices** and 90% of the non-mandatory **expected practices**.

- bb. Six weeks prior to an **Expected Practices** Compliance Audit, the CSA/designee shall complete the **Self-Evaluation Report** including the compliance tally, a signature, and the date. This report is to be **submitted** to the ACA **Accreditation Specialist** and the **CR, DOC ACA resource account** and shall be incorporated into the **Facility Narrative Summary** as part of the auditor's Welcome Book.

iv. Organization Summary **for Secure Residential Facilities**

- aa. The **Organization Summary for Secure Residential Facilities form** is **required to be** used to **outline** descriptive information about the facility **for submission to the ACA Accreditation Specialist and the CR, DOC ACA resource account**.
- bb. A facility undergoing an initial **Expected Practices** Compliance Audit **and Reaccreditation Audit** shall include the completed **Organization Summary for Secure Residential Facilities form** in its **Facility Narrative Summary**.

c. **Initial Audit**

**Initial audits are first-time audits and only require 12 months of documentation and the collection of data required for reports contained in the Facility Narrative Summary.**

d. **Reaccreditation Audits**

- (1) **Once a facility passes their initial audit, all future audits will occur every three years requiring continuous updating of supporting expected practices documentation and the collection of data beginning with the month after the last Visiting Committee audit report.**
- (2) **If a facility's accreditation status lapses, the facility will be required to undergo an initial audit as though starting over.**

2. Mock Audit Process

- a. **To help assess the facility's readiness for the upcoming accreditation audit, a mock audit shall be conducted at least four months prior to the scheduled ACA audit if resources permit. The mock audit shall be coordinated by the CSA/designee with neighboring facilities and consist of a tour of the facility by designated external teams to examine those areas directly related to the**

**mandatory expected practices that address life, health, and safety; to include at a minimum, but not limited to:**

- **physical plant**
  - **tool control**
  - **toxic/caustic inventories**
  - **fire/safety and sanitation**
  - **food codes**
  - **access to health care**
  - **conditions of confinement**
  - **inmate and staff morale**
  - **security**
  - **mandatory training**
- b. **Upon request, a solicitation for participants shall be sent out to neighboring facilities at least two months prior to the mock audit. Teams will be assigned to designated areas based on expertise and experience of the staff volunteers.**
- c. **Team members shall be provided with mock audit checklists containing specific items tied into policy requirements to review in their assigned areas, as well as interview questionnaires to conduct a limited number of random interviews with staff and inmates as time permits. Sample checklists are available in the ACA folder posted on SharePoint/File Share.**
- d. **Following the mock audit inspection, an exit briefing shall be held to review the findings and recommendations with facility representatives. Minutes from the exit briefing will be prepared and forwarded to the CR, DOC ACA resource account.**
- e. **Internal Standard File Review**

**The CSA/designee shall ensure that an internal standard file review is completed at his/her facility on a continuing basis.**

## **F. ACA Audit Overview**

### **1. Confirmation of *the* Audit**

Once a facility submits its **Organization Summary for Secure Residential Facilities form**, the ACA Accreditation **Specialist** sends a confirmation letter, the auditor contact information, and the **Public Notice** of the approaching audit via email to the **CSA/designee through the Central Office Chief of Accreditation/designee. The Public Notice is required to be posted in all common areas of the facility upon receipt and the Facility Narrative Summary shall** be provided to the auditors, based upon their preference, either in advance through the U.S. mail **or email**; or hand delivered the evening before the audit.

## 2. *Travel Arrangements*

- a. ***The facility is responsible for arranging hotel accommodations and local transportation for the Visiting Committee members to and from the airport, hotel, and facility. Hotels that offer special government rates should be given priority consideration. Auditors are responsible for payment of their hotel and meal expenses.***
- b. ***All*** members of the Visiting Committee usually arrive the evening prior to the first day of the audit. The Visiting Committee chairperson will convene an organizational meeting ***to*** establish a preliminary audit schedule and determine audit assignments ***by*** dividing sections of ***the accreditation manual*** among team members. ***The CSA/designee shall brief the team on the facility's expectations,*** review ***of*** any recent events that may affect the outcome of the audit, and answer questions regarding the materials ***received.***

## 3. Commencement of Audit

The Visiting Committee ***shall*** examine the Department's policies and procedures and the facility's operations to evaluate compliance with the ***expected practices for each*** standard based on the documentation provided by the facility. Accreditation is not determined or awarded by the Visiting Committee ***at the out-brief. Accreditation*** is determined ***at an ACA Conference following a hearing*** by the ***Commission on Accreditation for Corrections.*** In order to verify compliance ***of expected practices, the following activities shall be conducted by*** the Visiting Committee:

### a. Entrance Interview

- (1) An entrance interview is held on the first morning of the audit. In addition to the Visiting Committee, those present at the interview shall include the Facility Manager, ***CSA/designee, and Administrative Staff in addition to any*** other staff as determined by the Facility Manager. During the entrance interview, audit members introduce themselves and provide the facility with a summary of their backgrounds and credentials. The Visiting Committee Chairperson discusses the purpose of the audit, presents a tentative schedule of the audit team's activities, and responds to any questions that may arise concerning the conduct of the audit. ***The CSA/designee shall*** be available to the Visiting Committee at all times during the audit to answer questions, provide additional materials, and serve as liaison between the facility staff and the Visiting Committee.
- (2) The Facility Manager/designee may at his/her discretion, elect to keep other key staff members beyond their shift to assist the auditors.

### b. Facility Tour

- (1) Following the entrance interview, the Visiting Committee will tour the facility. Tours work in conjunction with an in-depth evaluation of written documentation to

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assist the Visiting Committee in assessing compliance for individual standards through their observations of the facility during the tour.

- (2) The tour includes all areas of the facility, and is intended to familiarize the Visiting Committee with the layout of the facility. In addition, the tour allows the Visiting Committee to meet supervisors and program staff. As they review the **expected practices** compliance documentation, Visiting Committee members will return to different areas of the facility to conduct more thorough inspections of the physical plant, observe facility operations, and interview staff and inmates. Visiting Committee members will also conduct an evening visit in order to acquire a better understanding of the overall operation and programming of the facility and to verify through observation the documentation reviewed during the day. Facility staff are notified when Visiting Committee members intend to return to the facility during evening hours.
- (3) The tour **shall** also include all living and sleeping areas **and any** areas related to the health and safety of staff and inmates. The Visiting Committee members are required to visit each shift, **eat at least one meal prepared by inmates at the facility, and observe inmate program activities. Auditors are interested in observing evening programs during regularly scheduled programming. When choosing audit dates, it is not advisable to select periods when educational programming is not scheduled.**

c. **Expected Practices** Compliance Review

- (1) Visiting Committee members will spend much of their time during the audit **working in the AARMS system** reviewing **expected practices** and documentation. In addition, interviews with individual staff and inmates are conducted, as necessary, to supplement the written evidence of compliance. The facility shall ensure that all appropriate personnel are available to the Visiting Committee members during the audit.
- (2) A room shall be provided where the Visiting Committee can work **privately** throughout the audit. This room should contain **workstations with** chairs, at least one large table, dual monitor computers with internet access, and should also afford the Visiting Committee a conducive **private working environment**.
- (3) Visiting Committee members **will also** review a random selection of **staff and** inmate files to ensure that forms are completed properly and **recordkeeping is current**.

d. Exit Interview

**After** the audit, the Visiting Committee meets with the **facility** staff to discuss the results of the audit. As with the entrance interview, the Facility Manager **shall** determine the staff **to** be present at the exit interview. It is the **CSA/designee's** responsibility to ensure that the exit interview is audio recorded and that the recording

is submitted to the Chairperson **after** the exit interview. The Visiting Committee reports all findings of non-compliant and non-applicable **expected practices** and states its reasons for each decision.

#### 4. **After the Audit**

The Audit Chairperson will provide the facility with a copy of the **Compliance Tally Sheet and compliance checklists for any expected practices** found in non-compliance **following** the out-briefing. The facility will have two weeks after the audit to provide their responses to non-compliant **expected practices** to the Audit Chairperson using the **Response to Non-Compliance Form available in the ACA folder on SharePoint/File Share. Response is achieved with a plan of action, request for a waiver of a plan of action, or an appeal** in accordance with **directions outlined in the ACA Manual of Accreditation Policy and Procedure (APM-1), which is located in the ACA folder on SharePoint/File Share.**

##### a. **Review of Visiting Committee Report (VCR)**

- (1) The results of the compliance audit are contained in the VCR.
- (2) Facilities shall review their final VCR reports **upon receipt** to ensure there are no inaccuracies **or** erroneous information. Any **recommended changes to the VCR** should be **identified and** forwarded to the **CR, DOC ACA resource account** for resolution **within five days of receipt**. Any follow-up items **posed by the Chief of Accreditation/designee shall** be responded to **via the resource account per established deadlines unless ACA requires the information sooner**. This includes verification and reconciliation of **SISs and Outcome Measures worksheets**.

##### b. **Non-Compliant Responses**

- (1) The **CSA/designee shall** review all responses to non-compliance before submitting them to the Audit Chairperson for inclusion into the VCR.
- (2) **Once the assigned ACA Accreditation Specialist receives the responses to non-compliance from the Audit Chairperson,** the final VCR **is then** sent to the Chief of Accreditation/**designee and the CSA**.
- (3) The VCR **is** submitted to the **Commission panel members** by the ACA Accreditation **Specialist** for consideration at the next regularly scheduled panel hearing.
- (4) **The CSA/designee shall also ensure that Non-Compliant Responses and the revised version of the VCR (if changes were made), are uploaded into the AARMS under the appropriate areas as part of the official record.**

c. Panel Hearings

- (1) ***The Commission on Accreditation for Corrections is solely responsible for rendering accreditation decisions and considers a facility's application at its next regular meeting following completion of the VCR.***
- (2) ***With the panel chairperson presiding, panel members discuss issues and raise questions relative to all aspects of agency operations and participation in the process. The information presented in the VCR and discussion by agency representatives during the hearing is considered in the decision making process and rendering of accreditation.***
- (3) ***The Facility Manager, CSA/designee, and any other staff designated by the Facility Manager shall participate and represent their facility, as directed by the Executive Deputy Secretary, at scheduled panel hearings telephonically or via electronic format.***
  - (a) ***The hearing will begin with an introduction of panel members and attendees which is usually followed with a request for the Facility Manager to provide a brief description of the facility's programs and involvement of any unique or special initiatives.***
  - (b) ***The panel chairperson leads the review of each individual non-compliance finding. The facility representative presents information relative to their requests for Waivers, Plans of Action, and appeals. The facility may also present additional materials, including photographs or documentation for review by the panel to support compliance.***
  - (c) ***In final deliberations, the Commission panel will ensure compliance with all mandatory expected practices and at least 90 percent of all other expected practices.***
  - (d) ***Following each applicant hearing, a reaccreditation roll call vote is conducted to consider the award of accreditation which is announced on record.***

d. ***Final Report***

- (1) ***Following the panel hearing, the facility will receive a Certificate of Accreditation/Reaccreditation, if found compliant. Panel hearing decisions are also provided formally in writing at a later date in a final Accreditation Audit Report.***
- (2) ***The CSA/designee shall review the final report to determine if any follow-up activity, as prescribed by the ACA panel, is required before uploading the report in the appropriate area in the AARMS system.***

## G. Ongoing Monitoring of Compliance

*The accreditation period is three years, during which time the facility must maintain the level of compliance achieved during the audit, and work towards compliance of those expected practices found in non-compliance.*

### 1. Annual Report

*During the three-year accreditation period, the facility is required to submit their Annual Report (utilizing the Annual Report form) to the ACA Accreditation Specialist and the CR, DOC ACA resource account. The report is due on the anniversary of the panel hearing at which accreditation was awarded.*

### 2. Critical Incident Report

*The facility is also responsible for notifying the ACA Accreditation Specialist of any critical incident that has the potential to affect expected practice compliance or facility accreditation as soon as possible within the context of the incident itself. This information is to be submitted to the ACA Accreditation Specialist and the CR, DOC ACA resource account using the Critical Incident Report form and, again, in a yearly summary as part of Attachment C of the Annual Report.*

## H. Department Employees Serving as ACA Auditors

Department employees serving as ACA auditors must use annual leave when conducting ACA audits. Auditors may accept the daily stipend from ACA; however, an approved **Supplemental Employment Application** must be on file for the employee to accept the stipend.

## Section 3 – Prison Rape Elimination Act (PREA) Audit Process

### A. General Overview

#### 1. Prison Rape Elimination Act (PREA) Standards

- a. The Department of Justice (DOJ) has enacted standards to establish clear goals and objectives to prevent, detect, and respond to prison sexual abuse. There are four sets of standards in the federal PREA legislation.
  - (1) All State Correctional Institutions (SCIs) operated by the Department are accountable to the Prisons and Jail Standards enacted by the DOJ.
  - (2) All Community Confinement Centers (CCCs) operated by the Department are held accountable to the Community Confinement Standards enacted by the DOJ.
- b. Most standards contain one or more of the following **provisions**:
  - (1) a requirement for policy and procedures;
  - (2) a required condition;
  - (3) a specific number (i.e. time frames); and
  - (4) a requirement that a process be in place.
- c. The Federal Register (Vol. 77, No. 119, 28 CFR Part 115) and Frequently Asked Questions (FAQ's) found on the PREA Resource Center website ([www.prearesourcecenter.org](http://www.prearesourcecenter.org)) are designed to clarify standards, provide guidance as to the intent of the standards, and offer information that might be used in implementing the standards.

#### 2. **PREA Auditing Requirements**

- a. Each facility operated by the Department **and contracted with the Department** is required to **undergo** an official PREA audit, conducted by a certified PREA auditor, once during **each** three year audit cycle. The **initial** PREA audit cycle began August 20, 2013. **(28 C.F.R. §115.401[a][b])**
- b. **During each one-year period of each audit cycle, the Department and multi-site contracted facilities with whom the Department contracts shall ensure that at least one-third of its facilities are audited.**

**The PREA Compliance Division (PCD) will develop and publish the Department's PREA audit schedule for each audit cycle to ensure that at least**



**one-third of its facilities of each type are audited each year of the audit cycle. Audit cycle year's end each August 19. (28 C.F.R. §115.401[b])**

- c. **Each audit requires facilities to provide a sampling of relevant documents, other records, and information for the most recent 12-month period, at a minimum. PREA auditors may request evidence of compliance beyond the preceding 12 months. (28 C.F.R. §115.401[g])**
- d. **The facility shall bear the burden of demonstrating compliance with the standards. The facility shall grant the auditor access to all areas of the facility during the on-site portion of the audit and provide copies of all requested documents, including those stored in an electronic format. (28 C.F.R. §115.401[e][h][i])**
- e. **Every provision of each standard is weighted equally. To be determined in compliance with PREA standards, the facility must demonstrate full compliance with all applicable provisions of the related standard. (28 C.F.R. §115.401[e])**
- f. **To achieve full compliance with its PREA audit, facilities must achieve a rating of "Meets Standard" or "Exceeds Standard" for all applicable standards (28 C.F.R. §115.401[e])**
- g. Each facility is required to **complete a Pre-Audit Questionnaire (PAQ)** at least four weeks prior to the on-site audit. **If the facility is being audited through the use of the PREA Online Auditing System (OAS), the OAS will automatically generate the PAQ through responses input into the system.**
- h. Additionally, the DOJ requires that facilities post public notices of an approaching PREA audit that invite the submission of written comments and information about the program from staff, inmates, and the public at least six weeks prior to the audit.

## **B. Responsibilities**

1. The PREA Compliance Manager (PCM)/designee shall perform the below listed tasks during each phase of the PREA Audit.
  - a. Pre-Audit Phase
    - (1) Develop a work plan that provides a structure for the facility's ongoing preparation for achieving or maintaining compliance with **the** PREA standards that include the following:
      - (a) the assignment of standards to appropriate staff for preparation in the OAS, if utilized by the auditor;
      - (b) the creation and maintenance of a local secondary documentation library on the facility's local computer network; and

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- (c) the scanning **and uploading** of **supporting** documentation.
  - (2) Ensure all required **audit notices** are displayed throughout the facility six weeks prior to the auditor's arrival. **Audit notices shall be posted in prominent areas where they are likely to be seen by inmates, staff, and visitors.**
  - (3) Complete the **PAQ and upload supporting documentation to the OAS, if utilized by the auditor, at least** four weeks prior to the on-site audit visit **and submit all audit materials to the PREA Coordinator/designee for review prior to submission to the PREA auditor. (28 C.F.R. §115.401[f][g][l])**
    - (a) **Within one week, the PCD shall submit a list of any recommended revisions to the PAQ or supporting documentation.**
    - (b) **Within three business days the PCM/designee shall complete all recommended revisions and submit the audit materials to the PREA auditor.**
  - (4) **Inform the respective individuals at** any hospitals and rape crisis centers who the facility has a Memorandum of Understanding (MOU) to deliver sexual abuse services, about the **impending audit for which they may be contacted. (28 C.F.R. §115.401[o])**
  - (5) **Communicate with the audit team in advance of the audit to develop a work schedule that meets the Department's and auditor's needs. Any necessary on-site accommodations shall be mutually agreed upon during pre-audit discussions.**
- b. On-site Audit Phase
- (1) Ensure electronic items and gate passes are approved and prepared for all members of the audit team upon arrival.
  - (2) Arrange for an introductory meeting with designated executive staff on the first day of the on-site audit.
  - (3) Prepare a tour itinerary to ensure that all inside and outside locations which inmates have access to are visited by the auditor/auditor team. **(28 C.F.R. §115.401[h])**
  - (4) Prepare lists of inmates and staff as requested by the PREA auditor to randomly select individuals for required interviews. **Lists should, at a minimum, include: (28 C.F.R. §115.401[k])**
    - (a) **a roster of the inmate population, sorted by housing unit;**
    - (b) **a list of known disabled and limited English proficient inmates;**

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- (c) ***a list of known Lesbian, Gay, Bisexual, Transgender, and Intersex inmates;***
  - (d) ***names of inmates placed in segregated housing for risk of sexual victimization (if applicable);***
  - (e) ***a list of inmates who reported sexual abuse;***
  - (f) ***a list of inmates who disclosed sexual victimization during risk screening;***
  - (g) ***shift rosters for all shifts during each date of the audit;***
  - (h) ***medical and mental health staff;***
  - (i) ***intake staff;***
  - (j) ***investigative staff;***
  - (k) ***intermediate or higher-level facility staff who conduct unannounced rounds;***
  - (l) ***volunteers and contractors who have contact with inmates;***
  - (m) ***staff who supervise inmates in segregated housing;***
  - (n) ***staff who serve on the Sexual Abuse Incident Review Team;***
  - (o) ***staff who served as a first responder to an allegation of sexual abuse;***
  - (p) ***staff who complete retaliation monitoring;***
  - (q) ***staff who complete PREA risk screening (PREA Risk Assessment Tool [PRATs]);***
  - (r) ***staff who supervise youthful inmates (if applicable); and***
  - (s) ***education and program staff who work with youthful inmates (if applicable).***
- (5) Ensure an appropriate, private space is available for auditor/auditor team to conduct interviews with staff and inmates. **(28 C.F.R. §115.401[m])**
- (6) Maximize on-site audit time by pacing a consistent flow of interviewees.

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- (7) Provide documented **or photographic** proof that deficiencies were corrected during the on-site audit as requested by the auditor, **or arrange for a second tour of the affected area.**
- (8) Arrange for an exit meeting with designated executive staff on the last day of the on-site audit.

c. Post-Audit Phase

- (1) Review the Interim PREA Audit Report for accuracy.
- (2) Correct all “Does Not Meet Standard” findings as expeditiously as possible.
- (3) Provide documented proof that any deficiencies noted in the Interim PREA Report were corrected in a timely manner.
- (4) Work with the PREA Coordinator/designee to correct any agency level deficiencies identified in the Interim PREA Audit Report.
  - (a) **All corrective action plans proposed by the facility or PREA auditor to address agency level deficiencies must be reviewed by the PREA Coordinator prior to implementation.**
  - (b) **The PREA Coordinator is responsible for vetting all agency level corrective action recommendations through the affected Bureau/Office within the Department.**

2. The PREA Coordinator/designee shall:

- a. provide training and technical assistance related to standards and audits to local facilities, as needed;
- b. schedule and coordinate PREA audits; and
- c. **review all pre-audit materials and provide facilities with a list of any recommended revisions, prior to the facility’s submission of the materials to the PREA auditor.**

**C. Audit Outcomes**

1. Does Not Meet Standard – This means the facility has not sufficiently proven compliance **with** the associated standard and additional information will be required in order to prove compliance. **(28 C.F.R. §115.403[c])** For each “Does Not Meet Standard,” the facility will have 180 days to provide sufficient documentation to prove compliance **with** that standard. **(28 C.F.R. §115.404[a])**

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2. Meets Standard – This means the facility has sufficiently proven compliance **with** the associated standard. **(28 C.F.R. §115.403[c])**
3. Exceeds Standard – This means the facility has proven **that it substantially exceeds the requirements of the** associated standard. **(28 C.F.R. §115.403[c])**
4. Not Applicable – There may be a standard that does not apply to the facility being audited and the facility has provided sufficient documentation to support such a finding.

#### **D. Audit Reports**

**One of the following** audit reports will be issued at the conclusion of the PREA Audit.

##### 1. Interim PREA Audit Report

- a. An interim report will be issued no later than **45** days after the last day of the on-site visit **if the facility is rated as “Does Not Meet Standard” for any applicable standard.**
- b. This report will identify an outcome finding for each PREA standard.
- c. For each standard that is marked “Does Not Meet Standard,” **the facility PCM will develop** a plan of action, in conjunction with the **PREA Coordinator and** PREA auditor, to achieve a “Meets Standard” or “Exceeds Standard.” **(28 C.F.R. §115.404[b])** The facility will have 180 days to provide sufficient documentation to meet compliance after issuance of the interim report.

##### 2. Final PREA Audit Report

- a. **A final report will be issued no later than 45 days after the last day of the on-site visit when the facility achieves a rating of “Meets Standard” or “Exceeds Standard” for all applicable standards.**
- b. **If the facility was issued an interim report, the** facility shall submit all required documentation to prove the standard is being met within the 180 day Corrective Action Period.
- c. Within 30 days of the end of the Corrective Action Period, the PREA auditor will send the final PREA Audit Report to the PREA Coordinator, the PCM/designee, and Facility Manager/designee indicating the audit outcome, **and a rationalization of how the facility achieved or failed to achieve compliance with all applicable standards.** **(28 C.F.R. §115.404[d])**
- d. The auditor’s final PREA report shall be displayed on the Department’s website for public review. **(28 C.F.R. §115.403[f])**

## E. Audit Appeals

1. Each facility will have the opportunity to lodge an appeal with the DOJ regarding any specific audit finding that it believes to be incorrect.
  - a. A facility who disagrees with the findings of the Interim PREA Audit Report should initially contact the PREA Coordinator/designee to facilitate an informal resolution with the PREA auditor.
  - b. If a resolution cannot be reached between the PREA Coordinator/designee and PREA auditor, and the finding is included on the Final PREA Audit Report, the facility is responsible for lodging an appeal with the DOJ within 90 days of the auditor's final determination. **(28 C.F.R. §115.405[a])**
2. If the DOJ determines that the Department has stated good cause for a re-evaluation, the Department may commission a re-audit by an auditor mutually agreed upon by the DOJ and the Department. The facility shall bear the cost of this re-audit. **(28 C.F.R. §115.405[b])**
3. The findings of the re-audit shall be considered final. **(28 C.F.R. §115.405[c])**

## F. Department Employees Serving as PREA Auditors

1. In accordance with PREA standard **28 C.F.R. §115.402**, Department employees, who are certified PREA auditors by the DOJ, may be required to conduct or participate in PREA audits.

***All Department employees who have participated in the DOJ's Auditor Training Program sponsored in any part by the Department of Corrections, are expected to utilize the training to conduct PREA audits under the Department's PREA auditing consortium. Auditors shall complete their audit activities in accordance with established protocols issued or published by the PREA Resource Center or the DOJ, and within the time frames imposed by the Department.***

2. ***The Department shall provide certified PREA auditors sufficient time away from regularly assigned duties to assist the agency with the completion of PREA audits covered by any interstate auditing consortium entered into by the Department including, but not limited to:***
  - a. ***coverage for regularly assigned duties during the on-site portion of audits;***
  - b. ***coverage for time required to generate the audit report; and***
  - c. ***coverage for time required to evaluate any required corrective actions.***

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3. Department employees, who are certified PREA auditors by the DOJ and conduct PREA audits through outside solicitation, must use personal or annual leave when conducting the PREA audit. Auditors may accept payment for the PREA audit; however, an approved Supplemental Employment application must be on file in order for the employee to accept the payment.
  - a. ***Consistent with PREA standard 28 C.F.R. §115.402, Department employees, who are certified PREA auditors, may not contract for audits of Department facilities or facilities under contract with the Department for a period of three years after the individual was last compensated by the Department.***
  - b. ***Department employees who are certified PREA auditors may conduct PREA audits for non-Department and non-Department contracted facilities for leave without deduction provided:***
    - (1) ***no payment is accepted for the audit; and***
    - (2) ***an executive summary of the audited facility's best practices is prepared and submitted to the Executive Deputy Secretary/designee.***

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**AARMS (Accreditation, Audit & Risk Management Security) System Administrator** – Department’s designee tasked with managing and maintaining the system as far as creating new user accounts, passwords, access rights, and training.

**AARMS (Accreditation, Audit & Risk Management Security) System** – Web-based audit and inspection management system that allows appropriate users to conduct audits and inspections against established standards with tools to track results instantly, monitor corrective action, and analyze trends statewide.

**Accreditation Hearing** – A final review of the Standards Compliance Audit by an Accreditation Panel appointed by the Commission on Accreditation for Corrections (CAC). The CAC Board of Commissioners is solely responsible for rendering accreditation decisions and is divided into Accreditation Panels empowered to render such decisions. Panels meet separately or in conjunction with a full board meeting and are composed of three to five Commissioners.

**Accreditation Program** – The ACA and CAC are private, non-profit organizations that administer the only national Accreditation Program for all components of adult and juvenile corrections. The purpose is to promote improvement in the management of correctional facilities through the administration of a voluntary Accreditation Program and the ongoing development and revision of relevant, useful standards.

**Accredited Status** – Granted upon compliance to 100 percent of the mandatory and 90 percent of the non-mandatory standards. During the three-year accreditation period, accredited facilities are required to submit annual certification statement, to include all outcome measures for the previous year, confirming standards compliance at levels necessary for maintaining accredited status. Monitoring visits and responses to specific issues may be required.

**Administrative Extension** – In the event that there is or will be a lapse period between an audit hearing date and/or reaccreditation confirmation, a facility may request a limited extension of Accredited Status. An extension may only be granted to accommodate extraordinary circumstances that are beyond the control of the facility.

**Agency** – An “agency” is the organization, facility, or program that is being audited.

**Annual Inspection** – A review of facility processes, procedures, or functions are examined by Central Office and facility staff to ensure that they are being accomplished as mandated by various laws, standards, directives, policies, and procedures.

**Annual Certification Statement** – Annual responses required to be submitted by a facility to the ACA confirming continued standard compliance with the standards, report on its progress of implementing plans of action, and advise the ACA of any significant events that may have occurred. It is due on the anniversary award, not the date of the initial/reaccreditation audit.

**Applicant Status** – Process to enter the Accreditation Program. The submission of an Organization Summary formatted by the CAC and a signed contract detailing fees, accreditation activity schedules, and related criteria are required to initiate the Accreditation Program process.



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The Department and CAC designate staff responsibility for organizing and supervising the program.

***Audit Appeal – A process arbitrated by the Department of Justice (DOJ), where a facility may challenge a PREA auditor’s finding that it believes to be incorrect.***

**Candidate Status** – Begins with the ACA’s acceptance of the Self-Evaluation Report or agency certification of its completion. Candidate Status continues until the facility meets the required level of compliance, has been audited by a Visiting Committee composed of ACA consultants, and has been awarded or denied a three year accreditation by the Board of Commissioners. Candidate status lasts up to 12 months. The facility may request, in writing, an extension of Candidate status. The facility requests a Standards Compliance Audit when compliance levels required for accreditation have been met or exceeded.

***Certified PREA Auditor – An individual who has completed the Department of Justice (DOJ) auditor training requirements and background check. Auditor certifications can be verified at <https://www.prearesourcecenter.org/audit/list-of-certified-auditors>.***

***Corrective Action Plan – A plan that is jointly developed by the facility and the auditor, outlining specific deliverables, time frames, and steps to take during the 180-day period triggered by a finding of “Does Not Meet Standard.” This plan includes the steps the auditor will take to reassess and verify the facility’s compliance at various stages throughout the process.***

**Correspondent Status** – Upon acceptance of the application, the facility enters Correspondent Status. The facility conducts a self-assessment of its operations and completes a Self-Evaluation Report (i.e. in-house mock audit) specifying the facility’s level of standards compliance. A Self-Evaluation Report includes an Organization Summary, a compliance tally, and preliminary requests for waivers of plans-of-action and completed Standards Compliance Checklists for each standard in the applicable manual.

**Department** – The Pennsylvania Department of Corrections.

**Executive Summary** – A summarization prepared by the inspector containing an overall assessment of the facility’s performance in meeting objectives, any significant findings, and recommendations.

***Expected Practices – Actions and activities that if implemented properly (according to protocols) will produce the desired outcome. They are what we think is necessary to achieve and maintain compliance with the standard – but not necessarily the only way to do so. They are activities that represent the current experience of the field, but that are not necessarily supported by research. As the field learns and evolves, so will the practices.***

**Facility** – Any State Correctional Institution, Community Corrections Center, Contract Facility, or Motivational Boot Camp operated by the Department.

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**Facility Manager** – The Superintendent of a State Correctional Institution, Motivational Boot Camp, Regional Director of a Community Corrections Center, and/or the Director of the Training Academy.

**Final PREA Audit Report** – *A PREA audit report that contains the auditors' final determination of whether or not the facility is in full compliance with all of the PREA Standards.*

**Full Compliance** – *A determination that a facility has complied with all material requirements of each standard except for de minimis violations, or discrete and temporary violations during otherwise sustained periods of compliance.*

**Inspection Standards** – A compilation of standards used during the inspection of each Department/area for evaluating compliance to policy and effectiveness of operational functions and programs.

**Inspection Team** – A team of Department staff that consists of Central Office Bureau/Office Directors, or Division/Unit Chiefs. This team of qualified staff compares established standards with existing practices and reports their findings.

**Interim PREA Audit Report** – *A PREA audit report that contains one or more findings of "Does Not Meet Standard." An interim report will contain recommendations for the formulation of a Corrective Action Plan.*

**Monitoring Status** – Approval of an extension of Accredited Status shall result in the facility being assigned Monitoring Status.

**Monitoring Visit** – An on-site visit by a representative(s) of the ACA to monitor and verify continued standards compliance or conditions of confinement.

**Multi-Site Contracted Facilities** – *An agency or organization, with whom the Department contracts for the housing of its inmates or reentrants, that operates more than one facility for the housing of inmates or reentrants.*

**Online Auditing System (OAS)** – *A web-based online interface for Department of Justice-certified PREA auditors and confinement facilities staff in the United States to complete audits on compliance with the Department of Justice's National PREA standards. Documentation collected during the audit process is securely retained within this system.*

**Outcome Measures** – Quantifiable (measurable) events, occurrences, conditions, behaviors, or attitudes that demonstrate the extent to which the condition described in the corresponding performance standard has been achieved. Outcome measures describe the consequences of the organization's activities, rather than describing the activities themselves.

**Organization Summary** – A form completed by the agency applying for accreditation/re-accreditation that provides ACA with descriptive information about the program or facility.

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**Pre-Audit Questionnaire (PAQ)** – *This tool is used to gather information at the preparatory stage of the audit. This document provides prompts for supporting documentation where necessary. When an audit is conducted within the Online Auditing System (OAS), the Pre-Audit Questionnaire is integrated within and does not require completion in a paper format.*

**Provision (aka: Element)** – *A specified condition or requirement within a PREA standard.*

**Reaccreditation** – To ensure continuous Accredited Status, an accredited facility shall apply for reaccreditation 12 months prior to the expiration of its current accreditation approval. A facility shall be audited from individual accreditation files and an assessment of the operations as they are being conducted.

**Reconsideration Process** – Process by which a facility may request reconsideration of any denial or revocation of accreditation. A reconsideration request is based on the grounds that the adverse decision is: (1) arbitrary, capricious, or otherwise in substantial disregard of the criteria and/or procedures for accreditation as promulgated by the ACA; (2) based on incorrect facts or an incorrect interpretation of facts or unsupported by substantial evidence. Written requests for reconsideration must be submitted to the ACA within 30 days of an adverse decision.

**Regional Inspection Captain** – A Captain assigned to a Regional Deputy Secretary who inspects Department facilities within a designated region with regard to security, emergency preparedness, tool control, key control, staffing patterns, etc., and ensures compliance with Department policy/procedure requirements.

**Revocation of Accreditation** – An accredited facility that does not maintain the required levels of compliance throughout the three year accreditation period, including continuous compliance with all mandatory standards, may have its Accredited Status revoked. Procedures are in place to allow for a grace period for corrective action and a probationary period for continued deficiencies, prior to revocation of Accredited Status.

**Self-Evaluation Report** – The document prepared by the agency in Correspondent Status that includes basic descriptive information about the agency, the results of the agency's assessment of its compliance with the standards including reasons for noncompliance and non-applicability, and a tally reflecting percentages of compliance with the standards.

**Significant Incident Summary** – A form that contains information regarding assaults, deaths, escapes, disturbances, and other significant events. The information must be provided for the 12 months preceding the audit. Agencies being considered for re-accreditation submit a completed Significant Incident Summary to ACA with the required annual report for the first two years of the reaccreditation cycle. It is also summarized in the audit narrative and included as an attachment to the final audit report.

**Standard** – *A statement that defines a required or essential condition to be achieved and/or maintained.*

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**Standards Compliance Audit** – An ACA appointed Visiting Committee conducts an on-site audit to measure the facility’s operation against CAC standards, based upon the documentation provided by the facility, facility tours, review of documents, interviews with staff and inmates, and reviews with facility administrators.

**Standards Compliance Checklist** – A form used in the standards compliance files to indicate the agencies and visiting committee’s determination on each standard (compliance, noncompliance, and non-applicability).

***Three-Year Audit Cycle*** – ***Three-year periods, beginning August 20, 2013, in which an agency must conduct a PREA audit in each of its facilities. NOTE: While the three-year audit cycle repeats on a calendar year basis, facilities do not require PREA audits on a three-year calendar cycle so long as they occur within the audit cycle.***

**Visiting Committee** – An ACA appointed committee that conducts a Standards Compliance Audit and prepares a written Visiting Committee Report to be submitted to the CAC. The ACA will designate a chairperson for the committee to organize and supervise the committee’s activities.