POLICY STATEMENT
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject:		Policy Number:
Inspections and Audits		**1.1.2**
Date of Issue:	**Authority:**	**Effective Date:**
February 14, 2024	**Signature on File** **Dr. Laurel R. Harry**	**February 21, 2024**

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) accreditation status and that an annual inspection or review to evaluate continued compliance with policy and ACA standards is completed at each facility.[1] Each facility shall ensure that compliance with the Prison Rape Elimination Act (PREA) is achieved and sustained through an audit by a Department of Justice Certified Auditor at least once per audit cycle.

IV. PROCEDURES

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

[1] 5-ACI-1A-17, 4-ACRS-1C-11, 4-ACRS-7D-02, 4-APPFS-3D-09

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

   a. 1.1.2, Inspections and Audits, issued April 11, 2019, by former Secretary John Wetzel.

   b. 8.1.1, Community Corrections Centers Procedures Manual, Section 22 – Adult Community Residential Services (ACRS) Accreditation Program issued October 18, 2012.

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. 4.1.1, Human Resources and Labor Relations

   c. 6.3.1, Facility Security

   d. 9.1.1, Correctional Industries

2. ACA Expected Practices

   a. Adult Correctional Institutions: 5-ACI-1A-17, 5-ACI-1A-19, 5-ACI-1B-12, 5-ACI-1D-03, 5-ACI-1F-12, 5-ACI-2A-01, 5-ACI-2A-02, 5-ACI-3B-01, 5-ACI-3B-11, 5-ACI-5C-09, 5-ACI-5D-01, 5-ACI-5E-05, 5-ACI-6A-29, 5-ACI-6D-02, 5-ACI-6D-09, 5-ACI-6D-10, 5-ACI-7A-07,

   b. Adult Community Residential Services: 4-ACRS-1C-11, 4-ACRS-7D-02

   c. Adult Probation & Parole Field Services: 4-APPFS-3D-09

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

   e. Correctional Industries: 2-CI-1B-1

3. PREA Standards (28 CFR Part 115)

   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.

Section 1 – Annual Operations Inspections

Section 2 – American Correctional Association (ACA) Accreditation Process

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

Section 1 – Annual Operations Inspections[1]

A. General

An annual Operations Inspection shall occur at each Department facility***, including State Correctional Institutions (SCIs) and Community Corrections Centers (CCCs). Parole Central Office shall be inspected annually while field offices and sub offices are inspected tri-annually. Inspections are intended*** to ensure consistent application of Department policies and ongoing compliance with internal standards, applicable accreditation expected practices, and law. Inspections shall be conducted by Subject Matter Experts (SMEs), fluent in the area being inspected. The intent of the inspection is to improve operational procedure and identify gaps between practice and expected practice before an extended pattern of non-compliance develops.

B. Responsibilities

1. Each Facility Manager/Center Director/***District Director/Deputy District Director***/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 advised when a notification has been received from the inspecting authority/designee that inspection results have been electronically entered in the designated electronic file system;

   c. the Corrective Plans-of-Action, as outlined in **Subsection *G*. below**, for addressing non-compliant inspection findings are prepared and entered into the electronic file system within 15 business days following receipt of the non-compliant notification from the inspecting authority/designee;

   d. the inspecting authority/designee is notified that Corrective Plans-of-Action have been entered and are available to review in the electronic file system. The ***applicable*** Executive Deputy Secretary for Institutional Operations (EDSI)/Regional Deputy Secretary (RDS), ***or Executive Deputy Secretary for Community Corrections, Reentry and Parole Field Services (EDSC), Deputy Secretary for Reentry, Deputy Secretary of Field Services***, 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 *G*. below**.

2. Each inspecting authority/designee/the Bureau of Community Corrections (BCC) ***Regional Director/designee, and Parole Accreditation Manager/designee*** shall ensure that:

[1] 5-ACI-6D-02, 4-APPFS-3D-09

Issued: 2/14/2024
Effective: 2/21/2024

a. they develop an annual inspection schedule and post on corresponding internal webpage by December 1 of each year for the following calendar year. The schedule shall ensure those facilities with American Correctional Association (ACA) audits occurring during the inspection year are inspected at least four to six months in advance of the audit;

b. appropriate staff with relevant knowledge and experience are identified to conduct the inspections. The inspection team may include staff from other facilities ***based on need, the individual's qualifications as an SME, and*** with their supervisor's approval;

c. division chiefs/***Regional Director/Parole Accreditation Manager/***designees train the inspection team members on the inspection format, criteria, reporting function, and their role in the process;

d. staff from his/her inspection area contact the Facility Manager/Center Director/***District Director/Deputy District Director***/designee of the facility to be inspected, coordinate the date(s) for the inspection, and notify the Facility Manager/Center Director/***District Director/Deputy District Director*** designee who will be conducting the inspection;

e. each inspection is conducted in accordance with the Operations/***Self Audit***/ACA Audit schedule;

f. if for some reason an ***inspecting*** authority cannot complete ***any*** inspection by the scheduled inspection date, they must receive approval from the ***applicable Deputy Secretary*** to change the date of inspection. The inspecting authority shall notify the facility of the approved delay and copy the **CR, DOC ACA** resource account;

g. an email is sent to the Facility Manager/Corrections Superintendent Assistant (CSA)/***Regional Director***/Center Director/***District Director/Deputy District Director***/designee notifying him/her that inspection results and an Executive Summary, summarizing the significant findings, have been entered and are available in the electronic ***file system*** no later than 15 working days following the audit;

h. an Executive Summary is a synopsis of the inspection and shall describe how the facility's observed practices align with the Department's expected practices. Executive Summaries shall contain significant findings and recommendations resulting from the inspection. The Executive Summary shall not be used to list each deviation from expected practice or reiterate deficiencies;

i. ***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 applicable EDSC and Deputy Secretary of Field Services, or the EDSI/RDS***;

j. facility Corrective Plans-of-Action are approved/disapproved, via the electronic file system workflow process, for each standard found to be non-compliant. An email shall

be sent to the Facility Manager/Center Director/***Regional Director***/***District Director/Deputy District Director***/designee notifying him/her that Corrective Plans-of-Action approvals/disapprovals are available in the electronic file system no later than 15 working days after the Corrective Plans-of-Actions have been entered into the electronic file system by the facility;

k. inspection/audit standards are reviewed annually and necessary changes are made by ***the first Friday in November each year*** to ensure that they are in line with current laws, policies/procedures, expected practices, and goals. Updated inspection standards shall be submitted to the Department Chief of Accreditation via the **CR, DOC ACA** resource account; and

l. to maintain inspection integrity throughout the inspection year, inspecting authorities shall not modify expected practices until the annual update, unless required by legal settlement, change in applicable laws, or changes in regulation.

3. The Department Chief of Accreditation/designee shall:

   a. maintain the schedule for Accreditation Audits and Annual Operations Inspections and post electronically by December 1 each year;

      (1) The Annual Operations Inspection schedule shall ensure those facilities with ACA audits are inspected four to six months prior to the audit or the ACA audit anniversary month in non-audit years.

      (2) The schedule shall afford 10 to 12 months between inspections and occurring four to six months prior to the facility's accreditation anniversary date***, where possible.***

   b. oversee and administer the electronic file system as well as provide technical assistance to facility staff;

   c. follow up with inspecting authorities on any delinquent reports that are past the submission due dates; and

   d. ***verify*** the annual review of current inspection standards by each inspecting authority at the end of each year to ensure ACA expected practices, legal mandates, policy compliance, and/or problematic issues are continually evaluated and updated.

4. The EDSI/RDS/***EDSC/Deputy Secretary of Field Services***/BCC Bureau Director/designee shall:

   a. review all annual inspection results and Corrective Plans-of-Action for each facility in his/her region and notify the facility whether the plans are acceptable or in need of revision; and

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b. review each facility's progress in resolving inspection discrepancies during the regularly scheduled quarterly facility visits.

C. Scope of the Audit – State Correctional Institutions (SCIs)[2]

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

1. Bureau of Standards, Audits, Assessments, and Compliance (BSAAC)

   Internal Policy Compliance Review shall be completed annually by the CSA. ***This review*** is not required when an ACA audit is conducted in the same calendar year.

2. ***Bureau*** of Population Management ***(BPM)***

   Inmate Records

3. ***Bureau of Facility Security and Special Operations (BFSSO)***

   An external security audit/inspection will be completed in accordance with Department policy **6.3.1, "Facility Security," Section 8**. This audit/inspection will take place during the year***(s)*** that the facility is not scheduled for an External Security ***and*** Vulnerability Assessment (***S***VA).

4. Bureau of Operations

   Maintenance — Construction[3]
   Capital Projects[4] — Environmental Issues
   Fire, Safety, Sanitation[5]

5. Bureau of Health Care Services (BHCS)[6]

   Medical Services[7]
   Food Service[8]
   Psychiatric Services (in conjunction with the Psychology Office)

[2] 5-ACI-1A-17, 5-ACI-1F-12, 5-ACI-6D-09, 5-ACI-7A-07
[3] 5-ACI-2A-01
[4] 1-CTA-2A-01
[5] 5-ACI-2A-02, 5-ACI-7A-07, 5-ACI-3B-01, 5-ACI-3B-11, 5-ACI-5C-09, 5-ACI-5D-01, 5-ACI-6D-02; 2-CI-1B-1, 1-CTA-2A-02, 1-CTA-3E-01, 4-ACRS-1C-11
[6] 5-ACI-6D-09, 5-ACI-6D-10
[7] 5-ACI-6D-09
[8] 5-ACI-5C-09, 1-CTA-3D-02

Issued: 2/14/2024
Effective: 2/21/2024

Psychology Office[9]
Psychology Services
Psychiatric Services (in conjunction with the Bureau of Health Care Services)

6. ***Public Safety Delivery Center (PSDC)***

   Delivery Center offices are subject to the Office of Administration's (OAs) Personnel Management Reviews ***and are not included in the Department's Operations Inspection process.***

7. 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.[10]

8. ***Division*** of Treatment Services[11]

   Counseling Services
   Substance Use Disorder Programs[12]
   PACT/Case Management
   Inmate Employment
   Volunteer Programs
   Religious Activities
   Recreational Activities
   Reentry Services Office/Veterans Service Unit (VSU) (in conjunction with BCC

9. ***Division of Correction Education***[13]

   Education/Voc-Ed Programs
   Library
   Barber School/Shop and Cosmetology Programs

10. ***Bureau*** of Training and Staff Development ***(BTSD)***

    Staff Training[14]

11. Correctional Industries (CI)[15]

    In accordance with Department policy **9.1.1, "Correctional Industries,"** all CI shops shall ensure that all required safety and environmental standards are met. CI operations

[9] 5-ACI-6A-29
[10] 5-ACI-1B-12
[11] 5-ACI-1A-17, 5-ACI-5E-05, 5-ACI-1F-12
[12] 5-ACI-5E-12
[13] 5-ACI-7A-07, 5-ACI-7B-01
[14] 5-ACI-1D-03
[15] 5-ACI-7A-07

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Effective: 2/21/2024

are subject to an independent financial review by the Department of the Auditor General or internal fiscal related audits as determined by Central Office.

D. Scope of the Audit – Community Corrections Centers (CCCs) and *Community Contract Facilities (CCFs)*[16]

An annual inspection shall encompass compliance with Department policies, applicable laws, procedures, practices, and related professional standards throughout the BCC. ***Broadly,*** the areas of inspection are listed below. The Deputy Director for Facilities Management (DDFM) and ***Regional Director*** are responsible for the coordination of the Annual Operations Inspection. Some of the identified areas may not be applicable to all facilities:

Facility
Security
Reentry
Administration
Prison Rape Elimination Act
Parole Violator (PV)

E. Scope *of the Inspection – Parole Field Offices*

1. ***Inspections of Parole Field Offices will occur on a three-year rotation.***

   a. ***Thirty days prior to the inspection, the Field Office will receive from the assigned Parole Auditor a notice of the upcoming inspection and a copy of the Inspection Workbook.***

   b. ***Prior to the on-site inspection, the inspection team will review five cases per unit including a cross-section of supervision levels using the Field OPS Inspection Case Review Checklist (Attachment 1-A).***

   c. ***Prior to the on-site inspection, the inspected location will upload the inspectable documents to the electronic filing system approximately ten working days in advance of the inspection for retention and preservation purposes. Any documentation obtained during the on-site visit will also be uploaded by the inspected location as well.***

   d. ***The lead auditor will create and submit the inspection report with the signatures of the entire Inspection Team.***

2. ***Inspections of Parole Field Offices shall be conducted by:***

   a. ***at least one parole auditor or parole auditor supervisor;***

[16] 4-ACRS-7D-02

(1) ***the parole auditor or parole auditor supervisor shall serve as team leader for the purposes of the inspection;***

(2) ***the parole auditor or parole auditor supervisor is responsible for directing/dividing up the work of the inspection for on-site and pre-site inspections; and***

(3) ***at the conclusion of the inspection, the parole auditor or parole auditor supervisor will enter the results of the inspection into the electronic file system;***

b. ***at least two District Directors or Deputy District Directors***

(1) ***District Directors or Deputy District Directors conducting the inspection may not be employed in the district in which the inspection is occurring; and***

(2) ***a Deputy District Director conducting an inspection should not be paired with his or her immediate supervisor on an inspection team.***

F. Inspection Process

1. The inspections of all functional areas identified in **Subsections C. and D. above** shall be conducted annually. ***The inspections described in Subsection E. above shall be conducted on a three-year rotation.***

2. The inspection of expected practices and inspection format shall be available in electronic format ***in a*** designated electronic file system. The facility will be able to access expected practices inspection format prior to the inspection in order to conduct a self-audit and to note any changes.

3. The inspectors will contact the Facility Manager/Center Director***/District Director/Deputy District Director***/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 ***inspecting authority*** will determine the size of the inspection team for his/her bureau.

5. Unassigned facility staff who have essential knowledge of the inspected area, or are participating for training purposes, may accompany the inspection team and assist with the inspection. They should be briefed by the individual(s) responsible for the particular inspection concerning their role in the inspection process.

6. Each inspector will annotate an inspection finding in the designated electronic file system for each inspection expected practice to indicate when the facility is compliant, non-compliant, or if the inspection expected practice is non-applicable as defined below.

    a. Compliant – the inspector observed evidence of the expected practice being consistently employed through a review of facility records, observation of facility procedures, interviews with staff and inmates, or other objective measure(s).

    b. Non-compliant – the inspector observed evidence that the facility has not implemented or does not consistently conform to the expected practice. This determination requires the inspector to record a rationale for the finding in the designated electronic file system.

    c. Non-applicable – the inspector determined that an absence of a condition triggering the expected practice exists at the facility. This determination requires the inspector to record a rationale for the finding in the designated electronic file system.

7. Following the inspection, an exit interview will be conducted with the Facility Manager/***Center Director/District Director/Deputy District Director***/designee(s), where preliminary findings of the inspection will be presented and discussed. Exit interviews may be conducted with individual or multiple inspection teams.

8. Inspectors may continue to evaluate compliance with expected practices following the on-site inspection. The exit interview shall not serve as notification of the inspection's final determinations.

G. Corrective Plans-of-Action

1. Corrective Plans-of-Action for addressing non-compliance issues identified by the inspection are prepared and submitted electronically into the electronic file system within 15 working days as outlined in **Subsection B.1.c. above**.

2. Progress reports shall be submitted by the Facility Manager/Center Director***/District Director/Deputy District Director*** within ***30 to*** 45 days, as applicable, ***or as directed by the inspector,*** at other increments deemed necessary by the inspector during a corrective action period not to exceed 180 days, to monitor the facility's progress in correcting all noted deficiencies.

3. The inspecting authority/designee shall review the Facility Manager/Center Director/***District Director/Deputy District Director's*** progress reports within seven days of submission.

4. Electronically filed Corrective Plan-of-Action Workflow

    a. Facility Manager/***Center Director/District Director/Deputy District Director/***designee

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Effective: 2/21/2024

(1) Notifies the inspecting authority that a Corrective Plan-of-Action has been completed for review.

(2) Notifies the inspecting authority that a ***30 to*** 45-day progress report has been completed for review.

(3) Notifies the inspecting authority that an incremental progress report***, as specified by the inspecting authority,*** has been completed for review.

(4) Notifies the inspecting authority that a final progress report has been completed for review within 180 days of notification of the non-compliant finding.

b. Inspecting Authority/designee ***(when applicable)***

(1) Notifies the Facility Manager/Center Director/***District Director/Deputy District Director/designee(s)*** that a Corrective Plan-of-Action has been ***reviewed; however, needs revision to address*** the corrective action taken.

(2) Notifies the Facility Manager/Center Director/***District Director/Deputy District Director/designee(s)*** that a Corrective Plan-of-Action has been ACCEPTED and a progress report must be submitted as soon as possible, but no later than 45 days.

(3) Notifies the Facility Manager/Center Director/***District Director/Deputy District Director/designee(s)*** of the intervals when additional progress reports may be required to ensure corrective action is completed within 180 days.

(4) Notifies the Facility Manager/Center Director/***District Director/Deputy District Director/designee(s)*** when progress reports have sufficiently demonstrated compliance and a final determination of COMPLIANT can be issued for the expected practice.

(5) Notifies the Facility Manager/Center Director/***District Director/Deputy District Director/designee(s)*** that a Corrective Plan-of-Action has NOT been accepted and provides further instructions.

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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, juvenile, community programs, probation, parole, and health services, to name a few.

2. Expected Practices Development

   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 ***location***, 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 ***location*** 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 ***location's*** conformance to professional standards.

2. Each Central Office Bureau of primary responsibility and each Facility Manager/***Regional Director/District Director/Deputy District Director/Pennsylvania Correctional Industries (PCI) Accreditation Manager/Bureau of Training and Staff Development (BTSD) (subsequently referred to collectively as Accreditation Manager[s])/***designee will monitor ***location*** 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 ***location/Parole Field Office/PCI/BTSD and contracted location*** will be required to achieve and maintain compliance with the accreditation program in accordance with the time frames outlined in the OPS/ACA Audit Schedule ***that is made available annually via electronic means.***

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C. Orientation and Training

1. All ***Accreditation Manager(s)/Parole Auditor Supervisor(s)/Parole Auditor(s)/Parole Manager(s)/***designee(s) shall be required to attend annual accreditation training as scheduled by the Bureau of Standards, Audits, Assessments, and Compliance (BSAAC). Training updates shall include***, and not be limited to,*** operations inspections, policy management, records retention, and ACA updates about the accreditation program and the maintenance of the electronic file system.

2. All staff are required to participate in the accreditation program at their respective ***locations***, and can access various training tools posted electronically for an understanding of the accreditation process.

D. Program Responsibilities – *State Correctional Institutions (SCIs)*

1. The Department Chief of Accreditation/designee shall:

   a. act as the liaison between the Corrections Superintendent Assistant (CSA)***, who is designated as the Accreditation Manager for SCIs,*** and the ACA Accreditation Specialist;

   b. provide training and technical assistance related to expected practices and accreditation to field staff, as needed;

   c. ensure the primary documentation is uploaded for all facilities in the designated electronic file system; and

   d. ensure that a mandatory ACA expected practice self-audit is scheduled four to six months prior to the ACA audit during the year that a ***location*** is scheduled to be audited.

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 Department's electronic file system used exclusively for ACA assessment purposes.***

      All forms referenced in this procedures manual and relevant materials can ***also*** be found in the ***electronic file system.***

   b. develop a plan of action for submission to the Facility Manager and Department Chief of Accreditation, that provides a structure for the ***location's*** ongoing preparation for achieving and/or maintaining compliance with ACA expected practices that includes the following:

      (1) the creation and maintenance of a local documentation library on the ***location's*** local computer network;

Issued: 3/15/2024
Effective: 3/22/2024

(2) the assignment of expected practices to appropriate staff for preparation in the electronic format for the designated electronic file system;

(3) the labeling, scanning, and uploading of process indicators/secondary documentation in electronic format in the designated electronic file system; and

(4) the completion and uploading of all required ACA reports in electronic format in the designated electronic file system for each audit cycle period.

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 self-audit is conducted annually in accordance with **Subsection *G.*3. below**;

e. ensure that a method for continuous data collection 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 period;[1]

f. ensure the **Organization Summary for Secure Residential Facility form** is prepared and submitted to the Department Chief of Accreditation via the **CR, DOC ACA** resource account for forwarding to the ACA Accreditation Specialist 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;

g. ensure that the **Facility Narrative Summary** is prepared in accordance with Department policy **1.1.1, "Policy Management System;"**

h. ensure that the ***location*** submits an **Annual Report** to the Department Chief of Accreditation via the **CR, DOC ACA** resource account for forwarding to the ACA Accreditation Specialist[2] on the anniversary of the ***location's*** last panel hearing in accordance with the **ACA Annual Report form** posted in the ACA folder on SharePoint/File Share; and

i. notify the Department Chief of Accreditation, via the **CR, DOC ACA** resource account, of any critical incident that has the potential to affect expected practice compliance or ***location*** accreditation as soon as possible within the context of the incident itself, using the **Critical Incident Report form** and, again, in a yearly summary as part of the Annual Report. The Department Chief of Accreditation shall forward this information to the ACA Accreditation Specialist.

[1] 5-ACI-1A-19
[2] 5-ACI-1A-19

E. Program Responsibilities – *Bureau of Community Corrections (BCC)*

1. The Department Chief of Accreditation/designee shall act as the liaison between the Bureau Director/designee and the ACA Accreditation Specialist.

2. The ***BCC Regional*** Director/designee shall serve as BCC's liaison to the Department Chief of Accreditation for all ACA and Operations Inspection activity.

3. The BCC ***Regional Director***/designee shall be responsible for the following:

   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 Department's electronic file system used exclusively for ACA assessment purposes;***

   b. act as the liaison between the Community Corrections Center (CCC) Director and the Department Chief of Accreditation;

   c. participate in internal audits and attend the ACA audit tour, at a minimum, for each CCC;

   d. develop a plan of action that provides structure for the ***location's*** ongoing preparation for achieving or maintaining compliance with ACA expected practices that includes:

      (1) the creation and maintenance of a local documentation library on the BCC's computer network;

      (2) the assignment of expected practices to appropriate staff for preparation in electronic format;

      (3) the collection, labeling, scanning, and uploading of process indicators/secondary documentation in an electronic format to the designated electronic file system; and

      (4) the completion and uploading of all required ACA reports in electronic format in the designated electronic file system for each audit cycle period.

   e. provide training and technical assistance related to expected practices and accreditation to CCC staff as needed;

   f. schedule and coordinate self-audits four to six months prior to the scheduled ACA audit to determine readiness for initial or re-audit and to identify any problem areas in the following areas:

      (1) documentation of mandatory files; and

      (2) inspection of all buildings/program areas with particular attention to fire/safety, sanitation, tool/key control, and security procedures.

g. ensure that internal self-audits are conducted quarterly and annually in accordance with **Subsection *G*.3. below**;

h. ***schedule and coordinate ACA audits in conjunction with the Department Chief of Accreditation, in accordance with the ACA contract;***

i. ***forward the ACA audit confirmation letter, auditor contact information, and accreditation notification to the CCCC Director immediately upon receipt no less than two weeks prior to the actual audit;***

j. ***prepare, maintain, and provide the accreditation, self-audit, and Annual Operations Inspection schedule to the Department Chief of Accreditation for posting. This schedule shall list:***

(1) ***the month of the CCC's ACA audit;***

(2) ***the month of the CCC's self-audit;***

(3) ***the month of the CCC's Annual Operations Inspection in accordance with Section 1 of this procedures manual;***

(a) ***the BCC Director/designee shall coordinate the Annual Operations Inspection with the inspecting authorities and the Regional Director to ensure that it occurs at least four months prior to the location accreditation anniversary date; and***

(b) ***if the Annual Operations Inspection cannot occur within the scheduled time period; the inspecting authority shall obtain the approval of the Deputy Secretary of Reentry to reschedule the inspection.***

k. collect, analyze, and submit Outcome Measures for each CCC in an electronic format for submission to the Department Chief of Accreditation;

l. ***ensure each CCC Director provides process indicators (evidence that practices were implemented properly) to the BCC Director/designee as directed;***

m. ***participate in self-audits and represent BCC at ACA audits for each CCC in his/her region;***

n. arrange hotel accommodations and local transportation for the Visiting Committee members as specified in **Subsection *H.2.* below**;

o. contact each Visiting Committee member prior to the ACA audit to confirm his/her flight information (arrival and departure) and hotel and travel arrangements;

p. ensure the ACA audit exit interview is tape recorded and the tape given to the Visiting Committee Chairperson for completion of the **Visiting Committee Report**; and

q. disseminate the **Final Accreditation Report** when received from the BSAAC to the Executive Deputy Secretary of Community Corrections and Reentry (EDSC), ***Deputy Secretary of Reentry,*** and BCC Director.

4. CCC Director

The CCC Director shall be responsible for the following:

a. coordinate ***location*** accreditation activity as directed by the BCC ***Regional Director/designee;***

b. collect and provide documentation of compliance with expected practices as prescribed by the BCC ***Regional Director/designee***;

c. complete an **Annual Report** in accordance with **Subsection *I*. below** and forward to the ***Regional Director and CR, DOC ACA resource account*** at the beginning of the anniversary month of the panel hearing at which accreditation was awarded;

d. assemble an Accreditation Team composed of staff members who will be responsible for determining compliance, compiling documentation, overseeing implementation of the expected practices, record keeping, and preparing plans of action. The staff selected for the Accreditation Team should have the ability to make decisions for their respective areas;

e. develop and maintain a regular meeting and review schedule for staff involved in the process. Meetings are held for staff to report on their progress, review potential deficiencies, and indicate when outside assistance is needed to clarify expected practices or accreditation policy and procedure. The CCC Director shall ensure there is regular and open communication with line staff, stressing support and expectations for the process;

f. review the electronic file system monthly to monitor when applicable inspection reports are filed and to begin developing plans of action to address non-compliant findings as appropriate. Inspection reports shall be maintained in applicable expected practice files;

g. ensure routine housekeeping and maintenance are completed, and physical plant issues are immediately addressed;

h. set up and track Outcome Measures in accordance with **Subsection *G*. below**;

i. ensure all appropriate Accreditation forms are completed and forwarded to the BCC ***Regional Director*** with a copy to the Department Chief of Accreditation via the **CR, DOC ACA** resource account as outlined in **Subsection *G*. below**;

j. participate in self-audits for other CCCs as directed; and

k. compile and provide a **Facility Narrative Summary** for each ACA Visiting Committee member in accordance with **Subsection *G*. below**.

5. CCC Staff

Each CCC staff member is responsible for performing all accreditation-related tasks as assigned by the CCC Director, Regional Director/designee, or BCC Director/designee.

F. ***Parole Field Services Procedures***

1. ***The Parole Accreditation Manager shall be responsible to:***

a. ***act as the liaison between the District Director/designee and the Department Chief of Accreditation;***

b. ***provide training and technical assistance related to expected practices and accreditation to Parole Field Services staff as needed; and***

c. ***assemble a Peer Accreditation Team composed of Parole Field Services management staff who will be responsible for determining compliance, compiling documentation, overseeing implementation of the expected practices, record keeping, and preparing plans of action.***

The staff selected for the Peer Accreditation Team shall be District Directors and Deputy District Directors from outside of the district which is being inspected.

2. ***The District Director/designee shall be responsible for the following:***

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 Department's electronic file system used exclusively for ACA assessment purposes;***

b. ***participate in internal audits and be present for the audit tour;***

c. ***develop a plan of action that provides structure for the district office/sub office's ongoing preparation for achieving or maintaining compliance with ACA expected practices that includes:***

(1) ***the creation and maintenance of a local documentation library on the Department's network;***

(2) ***the assignment of expected practices to appropriate staff for preparation in electronic format;***

(3) ***the collection, labeling, scanning, and uploading of process indicators/secondary documentation in an electronic format to the electronic file system; and***

(4) ***the completion and uploading of all required ACA reports in electronic format in the electronic file system for each audit cycle period.***

d. ***conduct necessary self-audits prior to the scheduled ACA audit to determine readiness for initial or re-audit and to identify any problem areas.***

3. ***The Parole Supervisor shall be responsible for the following:***

a. ***coordinate unit accreditation activity as directed by the District Director/designee; and***

b. ***collect and provide documentation of compliance with expected practices as prescribed by the District Director/designee or the Parole Accreditation Manager.***

4. ***Each Parole Agent shall be responsible for performing all accreditation-related tasks as assigned by the Parole Supervisor/District Director/designee.***

G. ***Pennsylvania Correctional Industries (PCI) Procedures***

1. ***The Department Chief of Accreditation/designee shall act as the liaison between the PCI Accreditation Manager and the ACA Accreditation Specialist.***

2. ***The PCI Accreditation Manager shall:***

a. ***act as the liaison between the PCI and field site staff and the Department Chief of Accreditation;***

b. ***provide training and technical assistance related to expected practices and accreditation to PCI and field site staff as needed;***

c. ***read and utilize as a desk reference the most current ACA Manual of Accreditation Policy and Procedure (APM-1);***

d. ***assemble an Accreditation Team composed of applicable management staff at both the PCI and field level who will be responsible for overseeing implementation of expected practices, collection of evidence of practice, record keeping, and preparing plans of action when applicable;***

e. ***develop a plan of action that provides structure for PCI's ongoing achievement or maintenance of compliance with ACA expected practices that includes:***

(1) ***the creation and maintenance of local supporting documentation libraries on PCI's shared network;***

(2) ***the assignment of expected practices to appropriate staff for preparation in an electronic format;***

(3) ***the collection, labeling, scanning, and uploading of process indicators in an electronic format to the electronic file system;***

(4) ***the completion and uploading of any applicable ACA Reports in electronic format in the electronic file system for each audit cycle period.***

f. ***conduct necessary self-audits prior to PCI's scheduled ACA audit to determine readiness for future compliance audits.***

3. ***PCI Manager (field sites)***

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 Department's electronic file system used exclusively for ACA assessment purposes;***

b. ***participate in location-based accreditation audit tours for both location level and PCI accreditation audits, as applicable;***

c. ***develop a plan of action that provides structure for the industry location's ongoing achievement or maintenance of compliance with ACA expected practices that includes:***

(1) ***the creation and maintenance of local supporting documentation libraries on the location's shared network;***

(2) ***the assignment of expected practices to appropriate staff for preparation in an electronic format;***

(3) ***the collection, labeling, scanning, and uploading of process indicators in an electronic format to the electronic file system; and***

(4) ***the completion and uploading of any applicable ACA reports in electronic format in the electronic file system for each audit cycle period for PCI and SCI accreditation audits, as applicable.***

d. ***conduct necessary self-audits prior to the field location's scheduled ACA audit to determine readiness for future compliance audits.***

4. ***Each PCI staff and field staff shall be responsible for performing all accreditation-related tasks assigned.***

H. ***Bureau of Training and Staff Development (BTSD) Procedures***

1. ***The Department Chief of Accreditation/designee shall act as the liaison between the BTSD Accreditation Manager and the ACA Accreditation Specialist.***

2. ***The BTSD Accreditation Manager shall:***

   a. ***act as the liaison between the BTSD and the Department Chief of Accreditation;***

   b. ***provide training and technical assistance related to expected practices and accreditation to the BTSD and agency training coordinators as needed;***

   c. ***read and utilize as a desk reference the most current ACA Manual of Accreditation Policy and Procedure (APM-1);***

   d. ***assemble an Accreditation Team composed of applicable staff who will be responsible for overseeing implementation of expected practices, collection of evidence of practice, record keeping, and preparing plans of action when applicable;***

   e. ***develop a plan of action that provides structure for the BTSDs ongoing achievement or maintenance of compliance with ACA expected practices that includes:***

      (1) ***the creation and maintenance of local supporting documentation libraries on the BTSDs shared network;***

      (2) ***the assignment of expected practices to appropriate staff for preparation in an electronic format;***

      (3) ***the collection, labeling, scanning, and uploading of process indicators in an electronic format to the electronic file system; and***

      (4) ***the completion and uploading of any applicable ACA reports in electronic format in the electronic file system for each audit cycle period.***

   f. ***conduct necessary self-audits prior to the BTSDs scheduled ACA audit to determine readiness for future compliance audits.***

I. Audit Preparation

1. Audit Types

   a. Initial Audit

The process leading to initial accreditation normally takes 12 to 18 months to complete. The SIS and Outcome Measures Report (OMR) require 12 months of data, documentation, ***and inclusion*** in the **Facility Narrative Summary**.

b. Reaccreditation Audits

(1) Once ***the location*** passes their initial audit, all future audits will occur every three years, in their audit anniversary month, requiring continuous updating of supporting expected practices documentation and the collection of data beginning with the month of the last ACA audit.

(2) If a ***location's*** accreditation status lapses, the ***location may*** be required to undergo an initial audit as though starting over.

2. Pre-Audit Activities – All ***Location*** Types

a. Development of Documentation

(1) Each ***location*** shall develop the appropriate local protocol (when necessary) and process indicator documentation for each expected practice contained in the designated electronic file system in accordance with the protocols listed in the ACA Expected Practice Protocol posted in the ***electronic file system*** and each expected practice's Self Help Key, if applicable.

(2) Each ***location*** shall ensure the documentation is uploaded ***electronically*** into each ***expected practice*** for each year of the audit cycle ***and includes appropriate highlights of relevant information that serves as evidence of compliance with the expected practice in its entirety, including each provision when applicable.***

(3) Each ***location*** shall ensure that all audit documentation complies with the Office of Chief Counsel's guidance ***on redaction*** which prohibits the inclusion of personal identifiers.

b. Accreditation Reports

In addition to the documentation requirements for each ACA expected practice, the ***location's Accreditation Manager/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 *(not applicable to Parole Offices)***

(a) The **Facility Narrative Summary** shall be completed and submitted in the proper format by ***the first Friday in November of each year*** in accordance with Department policy **1.1.1.**

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(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 and SIS ***applicable only to SCIs and BCC.***

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 *which is*** available in the ***designated electronic file system.***

bb. The **SIS** form requires information regarding assaults, disturbances, escapes, sexual violence, natural disasters, and unnatural deaths, to name a few.

cc. A ***location*** undergoing an initial ACA audit shall have the 12 months of the previous year leading up to the ACA audit entered and calculated on the **Outcome Measures worksheet** and shall complete the **SIS** form. Both forms shall be included as part of its **Facility Narrative Summary**.

dd. A ***location*** being considered for reaccreditation shall submit a completed **Outcome Measures worksheet *and SIS form*** with the required **Annual Report** to the ACA Accreditation Specialist[3] via the Department Chief of Accreditation/designee for the first two years of its reaccreditation cycle. The completed third year **Outcome Measures worksheet** and **SIS form** shall be included with the **Facility Narrative Summary** as part of the auditor's Welcome Book.

ii. ***ACA's Compliance Checklist/*Self-Evaluation Report**

aa. The **Self-Evaluation Report** is used to document the ***location'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 ***location*** 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.

[3] 5-ACI-1A-19

NOTE: The **Self-Evaluation Report** ***can be found in the designated electronic file system and*** is predicated upon the completion of the ***associated status*** for each expected practice. ***A hard copy of the Self Evaluation Report printed from the electronic file system is provided to the auditor(s) following the audit for auditor and ACA recordkeeping purposes.***

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

iii. ***ACA*** **Organization Summary** ***Form:*** Secure Residential Facilities, Non-Secure Residential Programs***, or Non-Secure, Non-Residential Organization Summary***

aa. The **Organization Summary** for Secure Residential Facilities, Non-Secure Residential Programs ***and Non-Secure Non-Residential Organization Summary*** forms are required to be used to outline descriptive information about the ***location*** for submission to the Department Chief of Accreditation via the **CR, DOC ACA** resource account.

bb. A ***location*** undergoing an ACA audit shall include the completed Organization Summary for Secure Residential Facilities, Non-Secure Residential Programs ***or Non-Secure, Non-Residential Organization Summary*** forms ***in*** its **Facility Narrative Summary**.

3. Self-Audit Process

a. As directed by the Department Chief of Accreditation, identified ***locations*** shall be subject to ongoing compliance monitoring to ensure audit readiness. In addition to the Annual Operations Inspection process outlined in **Section 1** of this procedures manual and the mandatory self-audit described below; identified ***locations*** shall be subject to remote compliance monitoring as outlined below:

(1) identified ***locations*** shall be responsible for uploading evidence of compliance to the designated electronic file system by a specified date, as directed by the Department Chief of Accreditation;

(2) ***locations*** shall be ***randomly*** audited via review of supporting documentation uploaded to the designated electronic file system;

(3) remote audits shall review select mandatory expected practices to ensure that all mandatory expected practices have been audited at least once during the audit year; and

(4) select non-mandatory expected practices shall be audited as deemed necessary to confirm ongoing compliance.

b. To help assess the ***location's*** readiness for the upcoming accreditation audit, a mandatory self-audit shall be conducted at least four to six months prior to the scheduled ACA audit, if resources permit. The self-audit shall be coordinated by the ***Accreditation Manager/***designee who will solicit participants from neighboring facilities ***or relevant Central Office Bureaus,*** four to six weeks prior to the self-audit. The self-audit will consist of a tour of the ***location*** by designated external teams formed based on the expertise of staff volunteers 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

c. Team members ***can access*** self-audit ***templates in the designated electronic file system. The templates*** contain 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.

d. Following the self-audit inspection, an exit briefing shall be held to review the findings and recommendations with ***location*** representatives. Minutes from the exit briefing shall be prepared, reviewed by the ***Accreditation Manager/designee***, and final reports shall be forwarded to the **CR, DOC ACA** resource account.

e. All self-audit findings shall be recorded in the designated electronic file system.

f. Internal Standard File Review

The ***Accreditation Manager/designee*** shall ensure that an internal standard file review is completed at ***their location*** on a continuing basis.

J. ACA Audit Overview

1. Confirmation of the Audit

   Once a ***location*** submits ***the ACA* Organization Summary *Report*** for Secure Residential Facilities or for Non-Secure Residential Programs, ***or Non-Secure Residential Organization Summary*** form, the ACA Accreditation Specialist sends, via the Department Chief of Accreditation, a confirmation letter, the auditor contact information, and the ***Location*** Notice of the approaching audit via email to the ***Accreditation Manager***/designee. The Public Notice is required to be posted in all common areas of the ***location*** 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, via email; or hand delivered the day before the audit.

2. Travel Arrangements

   a. The ***Accreditation Manager/designee*** is responsible for arranging hotel accommodations and local transportation for the Visiting Committee members to and from the airport, hotel, and ***location***. 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 can 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 ***Accreditation Manager/***designee shall brief the team on the ***location'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 ***location's*** operations to evaluate compliance of expected practices based on the documentation provided by the ***location***. Accreditation is not determined or awarded by the Visiting Committee at the out-brief. Accreditation is determined at a subsequent 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) State Correctional Institutions

         (a) 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 ***location*** 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 ***location*** staff and the Visiting Committee.

(b) The Facility Manager/designee may at his/her discretion, elect to keep other key staff members beyond their shift to assist the auditors.

(2) Community Corrections Centers (CCCs)

Those present during the entrance interview shall include, but not be limited to, the Regional Director, CCC Director, and other staff determined by the CCC Director. The CCC Director is designated as the primary liaison to the Visiting Committee and 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 CCC staff and the Visiting Committee.

(3) ***Parole Field Services***

(a) An entrance interview is held on the first morning of the audit. Those present during the entrance interview shall include the District Director or Deputy District Director who directly oversees the office being audited, the District Director (if not the same as above), at least 50% of the Parole Supervisors assigned to the office, and at least one Parole Agent from each unit assigned to the office. The District Director or Deputy District Director who directly oversees the office shall serve as the primary liaison between staff and the Visiting Committee and shall be available at all times during the audit to the Visiting Committee.

(b) The Parole Accreditation Manager shall host the entrance interview and serve as the primary liaison between staff and the Visiting Committee during the Central Office portion of the audit and shall be available at all times during the audit to the Visiting Committee.

(4) ***Pennsylvania Correctional Industries (PCI)***

An entrance interview is held on the first morning of the audit. Those present during the entrance interview shall include the PCI Director, Assistant Director, Accreditation Manager, and other designated staff deemed necessary by the PCI Director.

(5) ***Bureau of Training and Staff Development (BTSD)***

An entrance interview is held on the first morning of the audit. Those present during the entrance interview shall include the Bureau Director, Associate Director(s), Accreditation Manager, and other designated staff deemed necessary by the Bureau Director.

b. ***Location*** Tour

(1) Following the entrance interview, the Visiting Committee will tour the ***location***. The ***Accreditation Manager/designee shall*** develop a tour schedule that efficiently covers all areas of the ***location***. The tour schedule shall be incorporated into the ***location's*** Welcome Book as outlined in ***Subsection G.2.b.(1)(b) above. Tour schedules are not applicable to Parole offices.*** Tours work in conjunction with an in-depth evaluation of written documentation to assist the Visiting Committee in assessing compliance for individual standards through their observations of the ***location*** during the tour.

(2) The tour includes all areas of the ***location***, and is intended to familiarize the Visiting Committee with the layout of the ***location***. 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 ***location*** to conduct more thorough inspections of the physical plant, observe ***location*** operations, and interview staff and inmates/reentrants. Visiting Committee members will also conduct an evening visit in order to acquire a better understanding of the overall operation and programming of the ***location*** and to verify through observation the documentation reviewed during the day. ***Location*** staff are notified when Visiting Committee members intend to return to the ***location*** 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/reentrants. The Visiting Committee members are required to visit each shift, eat at least one meal prepared by inmates/reentrants at the ***location***, and observe inmate/reentrant 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 electronic file system, reviewing expected practices and documentation. The ***Accreditation Manager/designee*** shall be responsible for ***coordinating*** user rights and passwords in the electronic file system ***with master administrators for*** auditors at least 10 working days prior to their arrival and immediately ***coordinating revocation of*** such access following the audit.

(2) Interviews with individual staff and inmates/reentrants are conducted, as necessary, to supplement the written evidence of compliance. The ***location*** shall ensure that all appropriate personnel are available to the Visiting Committee members during the audit.

(3) 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.

d. Exit Interview

State Correctional Institutions (SCIs)

After the audit, the Visiting Committee meets with the ***location*** staff to discuss the results of the audit. As with the entrance interview, the ***location*** 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.

Community Corrections Centers (CCCs)

Those present during the exit interview shall include the Regional Director, Center Director, and other staff determined by the CCC Director. The Center Director shall ensure the exit interview is audio recorded.

Parole Field Services

Those present during the exit interview shall include the District Director or Deputy District Director who directly oversees the office being inspected, the District Director (if not the same as above), at least 50% of the Parole Supervisors assigned to the office, and at least one Parole Agent from each unit assigned to the office.

Pennsylvania Correctional Industries (PCI)

Those present during the exit interview shall include the PCI Director, Assistant Director, Accreditation Manager, and other designated staff deemed necessary by the PCI Director. The Accreditation Manager shall ensure the exit interview is audio recorded.

Bureau of Training and Staff Development (BTSD)

Those present during the exit interview shall include the Bureau Director, Associate Director(s), Accreditation Manager, and other designated staff deemed necessary by the Bureau Director. The Accreditation Manager shall ensure the exit interview is audio recorded.

4. After the Audit

The audit chairperson will provide the ***location*** with a copy of the Compliance Tally Sheet and compliance checklists for any expected practices found in non-compliance following the out-briefing. The ***location*** will be subject to a deadline established by the auditor following the audit to provide their responses to non-compliant expected practices, using the Response to Non-Compliance Form ***found in the electronic file system.***

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 ***electronic file system in the Training Materials folder and 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 VCRs upon receipt to ensure accuracy. Any recommended changes to the VCR should be identified and forwarded to the Department Chief of Accreditation, via the **CR, DOC ACA** resource account for resolution within five days of receipt. Any follow-up items posed by the Department Chief of Accreditation/designee shall be responded to via the **CR-DOC ACA** resource account per established deadlines unless ACA requires the information sooner. This includes verification and reconciliation of **SISs** and **Outcome Measures worksheets, *as applicable***.

b. Non-Compliant Responses

(1) The ***Accreditation Manager/***designee shall review all responses to non-compliance before submitting them to the Department Chief of Accreditation for forwarding 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 issued and sent to the Department Chief of Accreditation/designee and the ***Accreditation Manager/designee***.

(3) The VCR is then submitted by the Accreditation Specialist to the Commission panel members in preparation for the next regularly scheduled panel hearing.

(4) The ***Accreditation Manager/***designee shall also ensure that non-compliant responses and the revised version of the VCR (if changes were made), are uploaded in electronic format to the electronic file system 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/reaccreditation ***status*** and considers a ***location'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) Department staff shall participate in the Commission on Accreditation Hearings as directed by executive staff.

(a) The hearing will begin with an introduction of panel members and attendees which is usually followed with a request for the agency representative to provide a brief description of the ***location's*** programs and involvement in any unique or special initiatives undertaken since the audit.

(b) The panel chairperson leads the review of each individual non-compliance finding. The ***location*** representative presents information relative to their requests for waivers, plans of action, and appeals. The ***location*** 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 ***location*** 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 Department Chief of Accreditation/***Accreditation Manager/***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 electronic file system.

K. Ongoing Monitoring of Compliance

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

2. Annual Report[4]

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

L. 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.

[4] 5-ACI-1A-19

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 ***three*** sets of standards in the federal PREA legislation ***applicable to Department facilities. (28 C.F.R. §115)***

      (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 Corrections Centers (CCCs) operated by the Department, and contracted with the Department, are held accountable to the Community Confinement Standards enacted by the DOJ.

      (3) All Lockups within ***parole offices***/sub-offices are held accountable to Lockup 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), Frequently Asked Questions (FAQ's), and PREA Standards in Focus, found on the PREA Resource Center website (www.prearesourcecenter.org) are designed to clarify and explain the intent of the standards, and offer information that might be used in implementing the standards.

2. PREA Auditing Requirements

   a. The PREA audit cycle consists of a repeating three-year period and is divided into three distinct audit years, beginning August 20 and ending August 19 of the following year. The initial PREA audit cycle began August 20, 2013. **(28 C.F.R. §115.401[a][b])**

   b. Each SCI and CCC 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.

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c. Lockup facilities that do not house detainees overnight are not subject to audit. **(28 C.F.R. §115.401[a][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 of each type are audited. Audits are not required to occur on a three-year calendar schedule; rather, must occur once per cycle***, and may occur in less than three years since the previous audit.***

d. The Department's PREA coordinator shall develop and publish the Department's PREA audit schedule for each audit *cycle period which ends on August* 19. **(28 C.F.R. §115.401[b])**

e. Each audit requires facilities to provide a sampling of relevant documents, other records, and information ***as evidence of compliance*** for the most recent 12-month period, at a minimum. PREA auditors may request evidence of compliance beyond the preceding 12 months. ***Records in support of compliance shall be provided during all phases of the audit, including the pre-audit, onsite audit, and post-audit phases as necessary.*** **(28 C.F.R. §115.401[g])**

f. 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])**

g. Every provision of each standard is weighted equally. To be determined in compliance with PREA standards, the facility shall bear the burden of demonstrating full compliance with all applicable provisions of the related standard. **(28 C.F.R. §115.401[e])**

h. 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. §115.403[*c*])**

i. Each facility is required to complete and submit a Pre-Audit Questionnaire (PAQ) at least four weeks prior to the on-site audit. ***All audits are required to be completed through the*** PREA Online Auditing System (OAS). The OAS will automatically generate the PAQ through responses input into the system.

j. 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 for review by Facility Administration and Department PREA coordinator, 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

(c) the scanning and uploading of supporting documentation.

(2) Ensure all required audit notices are displayed throughout the facility ***at least*** 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. To ensure adequate visibility, audit notices ***are recommended to*** be printed on brightly colored paper when available.

(3) At the request of the auditor, facilities may be required to provide photographic verification, via the OAS, of the audit notice posting.

(4) Complete the PAQ and upload supporting documentation to the OAS at least five 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.

(5) Inform the respective individuals at any hospitals and rape crisis centers who the facility utilizes for such services or 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])**

(6) Communicate with the ***auditor*** 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 and approved by the facility manager.

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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;

(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 or who have reported sexual abuse (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) security and non-security 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 screenings (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) Interview locations should be in an area of the facility where inmates ordinarily report for callouts to maximize the opportunity for an inmate's participation to remain private.

(7) Maximize on-site audit time by pacing a consistent flow of interviewees.

(8) ***Position all files and documentation that the auditor has requested to review onsite in a centralized location, accessible to the auditor for efficient review between audit interviews or other periods of idle time.***

(9) 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.

(10) Arrange for an exit meeting with designated executive staff on the last day of the on-site audit.

c. Post-Audit Phase

(1) ***Answer all questions posed by the auditor and provide requested documentation during the interim report period, as soon as possible.***

(2) Review the Interim PREA Audit Report for accuracy.

(3) Correct all "Does Not Meet Standard" findings as expeditiously as possible.

(4) Provide documented proof that any deficiencies noted in the Interim PREA Report were corrected in a timely manner. ***Upload supporting evidence to the OAS supplemental file folder.***

(5) 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 ***evidence*** to prove compliance with that standard. **(28 C.F.R. §115.404[a])**

2. Meets Standard – This means the facility has sufficiently proven compliance with the associated standard ***or has proven that the associated standard is not applicable to the facility.*** **(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])**

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 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 manager 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 manager 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. 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 Supplementary Employment application, in accordance with **Department policy 4.1.1, "Human Resources and Labor Relations," Section 58,** 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 report of the audited facility's best practices is prepared and submitted to the Executive Deputy Secretary ***of Institutional Operations (EDSI)***/designee.

Definitions of American Correctional Association (ACA) terminology cited in Department policy 1.1.2 related to ACA can be found in the American Correctional Association APM-1 March 15, 2017, and the most current applicable Performance Based Expected Practice Manual.

Accreditation Panel – The subunit of the Commission on Accreditation for Corrections empowered to review applications and make final decisions on agency accreditation.

Accredited Status – The three-year accreditation period ***which the agency maintains and improves upon its standards compliance levels that were achieved at the time of the accreditation award***.

Agency – ***The unit of a governing authority that has direct responsibility for the operations of a corrections program, including the implementation of policy as set by the governing authority.***

American Correctional Association (ACA) – Is a professional membership organization composed of individuals, agencies, and organizations involved in all facets of the corrections field, including adult and juvenile services, community corrections, probation and parole, and jails.

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

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.

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 – ***In response to*** a finding of "Does Not Meet Standard" ***in a PREA audit, a corrective plan of action*** is jointly developed by the facility and the auditor, outlining specific deliverables, time frames, and ***methods by which*** the facility's compliance ***will be reassessed. A corrective action plan must be completed within 180 days of its initiation***.

Department – The Pennsylvania Department of Corrections.

Executive Summary – ***A synopsis of the inspection that describes how the facility's observed practices align with the Department's expected practices. Executive Summaries contain significant findings and recommendations rather than deviations from expected practices or deficiencies***.

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.

Facility Manager – The Superintendent of a State Correctional Institution, Motivational Boot Camp, 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 ***developed by internal inspecting authorities and expected practices, including ACA expected practices,*** 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 processes*** 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.

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.

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

Outcome Measures – Measurable events, occurrences, conditions, behaviors, or attitudes that demonstrate the extent to which the condition described has been achieved.

Pre-Audit Questionnaire (PAQ) – This tool is used to gather information at the preparatory stage of a PREA 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.

Progress Report – A status update, describing a facility's efforts to resolve an identified deficiency during an Operations Inspection, leading to a corrective plan of action. The progress report allows an inspector to assess whether the actions taken by the facility will sufficiently resolve the deficiency within the specified corrective action period or whether alternative actions or strategies are necessary.

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.

Regional Inspection Captain – A Captain assigned to ***an Executive Deputy Secretary for Institutional Operations (EDSI)***/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.

Self-Audit – (aka mock audit). A self-audit is an internal audit completed four to six months prior to an ACA accreditation/reaccreditation audit by local facility personnel. In comparison to a mock audit, which previously involved subject matter experts from neighboring facilities to assist with the internal evaluation, the self-audit is more flexible in so much as local subject matter experts may complete the self-audit exclusively with or without the assistance of outside inspectors should they be unavailable to assist.

Self-Evaluation Report – A summary of the facility's internal assessment of compliance with expected practices, formulated through a review of the Standards Compliance Checklists applicable to the facility type and manual under which the facility is to be audited. Standards Compliance Checklists must be completed and tallied to formulate the Compliance Tally within the Self Evaluation Report.

Significant Incident Summary – ***A required report to be completed for all residential accreditation programs. It*** contains information regarding assaults, disturbances, deaths, escapes, and other significant events. The information must be provided for the 12 months preceding the ***actual ACA*** audit. Agencies being considered for reaccreditation 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.

Standard Compliance Checklist – A form which describes each expected practice and contains a column which records the facility's self-evaluation of compliance with the expected practice along with the rationale for the finding. The form also contains a

column titled Standards Compliance Audit Visiting Committee which is completed by auditors while on-site. The checklist must be saved with other audit information.

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.

Three-Year Audit Cycle – ACA – Three-year audit cycle periods that are calculated for recordkeeping purposes. The audit cycle is based on calendar years. Each year of the audit cycle begins with the anniversary month and concludes at the end of the month preceding the actual ACA audit anniversary month.

Visiting Committee – An ACA appointed committee ***of up to three members*** that conducts ***the ACA*** Audit and prepares a written Visiting Committee Report ***for submission*** to the CAC. ***Also known as the "eyes and ears" of the Commission.*** ACA ***designates one of the members to act as the*** chairperson ***who is responsible for organizing and supervising*** the committee's activities.