Massachusetts Department of Correction **POLICY**	Effective Date 7/24/2026 Annual Review Date 7/24/2026	Responsible Division Policy Development and Compliance Unit
Policy Name 103 DOC 112 INSTITUTION ASSESSMENT / INSPECTION	Regulation Reference: Chapter 124 §§ 1(c), (d), (q); Chapter 127, § 1(a), (b) DOC Policy Reference: 103 DOC 100; 103 DOC 504 ACA/PREA Standards: 5-ACI-1A-17; 5-ACI-1A-19; 5-ACI-3A-11; 2-CO-1A-22; 4-ACRS-7D-02; 1-CTA-3B-01	
Attachments Yes ☐ No ☒ Library Yes ☒ No ☐	Applicability: Staff	
Public Access Yes ☒ No ☐	Location: Department Central Policy File Superintendents/Unit Directors Policies Files	

PURPOSE:
The purpose of this policy is to establish departmental policy regarding institution assessments/inspections.

RESPONSIBLE STAFF FOR IMPLEMENTATION AND MONITORING OF POLICY:
Director of the Policy Development and Compliance Unit
Assistant Deputy Commissioners
Superintendents

CANCELLATION:
This policy cancels all previous department policy statements, bulletins, directives, orders, notices, rules and regulations regarding institution assessment/inspection which are inconsistent with this policy.

SEVERABILITY CLAUSE:
If any part of this policy is for any reason held to be in excess of the authority of the Commissioner, such decision shall not affect any other part of this policy.

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112.01 INSTITUTION ASSESSMENTS

A. In accordance with statutory regulations, the Commissioner, through the Policy Development and Compliance Unit (PDCU), shall assess the level of compliance with the established standards for all state correctional institutions.

B. The state standards shall consist of departmental and institution-specific policies and procedures as well as the American Correctional Association (ACA) standards, and other standards deemed appropriate by the Commissioner.

C. The Director of the PDCU shall ensure audits are conducted in accordance with an established schedule at institutions/department units to ensure that all policies, procedures, and operating manuals are current, operationally sound, and reflect existing Department policy/regulations.

D. State institutions are also required to comply with the established regulations or standards set by the appropriate federal, state, or local authorities in such areas as life, health, fire, environmental safety, and sanitation.

112.02 INSTITUTION ASSESSMENT/INSPECTION PLAN

A. Each Superintendent shall develop written assessment/inspection procedures as part of the institution's policy manual, which include, but are not limited to:

1. Administrative patrols and inspections of living and working conditions, programs, and the security, safety, and sanitation of the institution in accordance with 103 DOC 504, *Security Inspections*.

2. Procedures detailing how often and by whom the specific inspection/audit reporting(s) are done.

a. At a minimum, each institution and division that is audited by the PDCU shall be required to conduct internal audits for each applicable area listed in PowerDMS, under Documents/DOC Policy Manual/Audit Tools.

b. Utilizing the above referenced audit tools, designated staff members of a supervisory rank/job title shall audit each area at least annually and ensure that practice reflects current Department policy and institution procedure.

c. The results of these internal audits shall be documented in

writing and submitted to the Superintendent/Division Head or designee for review. Once reviewed, the Superintendent/Division Head or designee shall be required to develop a plan of action with a follow-up date to address any deficiencies cited.

d. The institution's Director of Security (or equivalent position) shall keep the completed internal audit forms and plans of action on file for a period of three (3) years.

112.03 ROLES AND RESPONSIBILITIES FOR AN INSTITUTION ASSESSMENT

A. Auditor Standards

1. Qualifications: The staff assigned to conduct an audit should collectively possess adequate professional proficiency for the tasks required. The Director of the PDCU has the discretion to select auditors.

2. Independence: Each member of the auditing team should maintain an independent attitude and appearance. Independence must be maintained so that conclusions and recommendations shall be accepted as objective and unbiased.

3. Due Professional Care: Each auditor must exercise due professional care in conducting the audit and in preparing related reports. Good professional judgment must be used in assessing the various operations and programs. Timeliness in reporting and proper handling of sensitive or confidential information is essential.

B. Director of the PDCU

The Director of the PDCU is responsible for coordinating the auditing process throughout the Department of Correction. Pursuant to that task, the Director:

1. Serves as a reviewing authority for all departmental audits conducted;

2. Develops and updates the auditing policy and procedures;

3. Annually issues the auditing schedule for all audits;

4. Selects auditors based upon their evaluation skills, ability to communicate, and knowledge of a given operations or program area;

5. Ensures that audits are conducted in a timely and professional manner;

6. Ensures that audit reports are prepared in a timely and professional manner;

7. Maintains an effective follow-up system to ensure that corrective actions are taken;

8. May participate in audits and provides auditing skills training and technical assistance to auditors;

9. Conducts on-site evaluations of auditors;

10. Provides analysis and feedback to affected parties relating to auditing results; and

11. Makes recommendations to the Commissioner for improvements in institution operations, department policy and the auditing process.

C. Superintendents

The Superintendents' responsibilities shall include the following:

1. Provide full support and cooperation to the auditors, including freedom of access to all property, records, employees, incarcerated individuals and civil commitments;

2. Ensure that, barring an emergency, the audit is given priority-one attention for its entire duration;

3. Ensure that all key staff are available for the duration of an audit. Key staff are those most familiar with or responsible for any given operation or program area. If the primary key staff person is not available, a secondary key staff person, who is comparably qualified, must be available to answer questions or assist the auditor;

4. Provide timely initiation and completion of appropriate corrective actions; and

5. Taking any necessary action to correct deficiencies cited and to improve internal controls.

6. Ensure that adequate controls are implemented to avoid the recurrence of deficiencies.

D. Assistant Deputy Commissioner (ADC)

The ADC's responsibility shall include the following:

1. Ensure that Superintendents are fully responsive during the auditing process, to the audit findings, and that such findings are responded to in a timely manner;

2. In conjunction with the Commissioner, determine the need for special audits, which may be broad based or limited in scope to a particular operation or program area, or request that particular emphasis be given to an area during an audit;

3. Monitoring the implementation of corrective actions and internal controls of their respective institutions, and;

4. Analyze the audit reports of their respective institutions to determine if there is a pattern of non-compliance or other significant issue(s).

112.04 PRE-AUDIT PLAN

A. At least annually, members of the PDCU and other selected departmental staff shall visit each state institution in order to assess each institution's adherence to department and institution policies and procedures as well as to the ACA standards.

B. Superintendents shall ensure, to the degree possible, that all key staff are available for the duration of the audit.

C. Institution staff shall have the opportunity to be orally informed of all significant findings prior to the end of the audit.

D. The following general areas may be assessed at each audit:

a. Security
b. Safety
c. Sanitation
d. Food Services
e. Medical Treatment

f. Maintenance
g. Administration
h. Fiscal
i. Training
j. Personnel
k. Incarcerated Individual and Civil Commitment Treatment
l. IMS Utilization, and
m. The Accreditation Process

The specific areas being assessed may vary from institution to institution as well as from audit to audit depending upon current departmental initiatives or particular areas of concern within a given institution.

E. Purpose of PDCU Audits

The purpose of institution audits are as follows:

1. Provide assistance to management by recommending solutions to problems;

2. Ensure conformity with applicable law, regulations, policies and procedures;

3. Identify weaknesses in internal controls to determine if corrective action is needed before they are revealed by the incarcerated and civilly committed populations through escapes, assaults, disturbances, or litigation;

4. Identify exemplary practices and promote their recognition and replication;

5. Review past and present performance;

6. Promote efficient management practices; and

7. Prevent, detect, and report any instances involving mismanagement, waste, abuse, or illegal acts.

F. Scope

1. Generally, audits shall cover at least the areas highly vulnerable to risks, e.g., security, safety, and sanitation.

2. Audits may focus upon institution-specific issues relating to ACES objectives relevant to 103 DOC 100, *Department Vision, Mission and Quarterly/Annual Reports,* ACA accreditation preparation,

areas previously reported as deficient, or as a result of recent incidents.

3. Audit length may vary depending upon the scope and the findings. The Director of the PDCU has the discretion to determine the length of an audit.

4. Auditors are not constrained from examining areas other than those initially planned if evidence leads them to do so.

5. Institution personnel must grant auditors access to all documents needing review, permit ample latitude for interviewing staff, incarcerated individuals, and civil commitments, and allow inspection of all areas and items of state property. This section is not intended to circumvent established procedures limiting access to certain records, e.g., medical information (HIV), etc. On-site staff should pursue obtaining any necessary permission whenever appropriate.

6. Should conditions exist that limit or restrict an auditor's ability to perform the audit, the chairperson should attempt to informally resolve the issue. If the issue is not resolved informally, the chairperson shall report the problem to the appropriate Assistant Deputy Commissioner and Deputy Commissioner and shall document it in the working papers and the final written report.

G. Audit Scheduling

1. The Director of the PDCU shall develop and distribute the upcoming fiscal year's auditing schedule via email to all Superintendents and Executive staff.

2. The audit schedule shall identify the projected month of each institution's audit.

3. At least thirty (30) days in advance of the audit, the Director of the PDCU shall send a written notice to the affected Superintendent and Assistant Deputy Commissioner, informing them about the audit. The notice shall include the following:

   a. The dates of the audit;
   b. Either a general or specific statement concerning the scope of the audit;
   c. A request for the availability of any specific information needed from the review site; and

d. A request that the Superintendent or Assistant Deputy Commissioner respond if there are any additional or special concerns needing examination.

4. If the date(s) of the audit must be changed, the Director of the PDCU or designee shall inform the affected Superintendent and Assistant Deputy Commissioner and shall attempt to reschedule as soon as possible. If the audit is postponed beyond thirty (30) days, another written notice shall be sent.

5. The Commissioner reserves the right to initiate an audit without prior written notice.

112.05 AUDIT PROCESS

A. Audits consist of a complete examination of one (1) or more components of an institution's physical plant, accreditation process, operations, and programs. Each audit shall be conducted by one (1) or more auditors. The chairperson of the audit team shall ensure that:

1. The audit is conducted in accordance with policy and procedure;

2. All findings and recommendations are presented in a written report to senior management;

3. Auditors receive sufficient supervision and guidance; and

4. An overall rating is provided for each area assessed.

112.06 STAGES OF AN AUDIT

There are five (5) interrelated stages to an audit. The order in which they are performed may vary from time to time:

A. Preparation

The auditors should familiarize themselves with the previous audit's findings and with other relevant information such as recent incidents, trends observed, and the Department of Public Health's (DPH) inspection report(s).

B. Examination

1. This stage involves collecting data, touring the physical plant, and interviewing staff, incarcerated individuals and/or civil commitments.

a. The chairperson shall meet with the other auditors to brief them on the audit plan. This meeting should include a discussion of the time frames, objectives, division of labor, manner of sampling (number, time span reviewed), persons to be interviewed, and processes to be observed. Emphasis should be placed on being as unobtrusive as possible.

b. Key on-site staff, as determined by the Superintendent, should be afforded the opportunity for full involvement. The chairperson shall inform the key staff that all comments that may alter findings or recommendations shall be investigated and given due consideration.

c. The audit team will meet daily with the Superintendent to orally apprise institution staff of their observations made and provide sufficient details to allow a full understanding. A record of these interim meetings shall be kept with the working papers.

d. The auditors shall consider the objective of each operation or program and their significance to either the institution's or department's mission, assess the level of risk for something going wrong, review the adequacy of established procedures and prepare specific recommendations accordingly.

2. Evidence: During the examination stage data is collected. This data is considered evidence to support the conclusions contained in the final written report. There are four (4) types of evidence:

a. Physical: Direct observation of people, property, or processes (most reliable);

b. Testimonial: Interviews (least reliable, seek corroboration);

c. Documentary: Files, records, invoices (helpful, but auditors should not spend an undue portion of time reading documents); and

d. Analytical: Making judgments through computations, reasoning, comparisons, etc.

3. Standards of Evidence: Evidence must meet the following three (3) standards in order to be included in the final written audit report:

a. Sufficiency: There must be enough factual, convincing evidence to lead a person who is not an expert in the area to the same conclusions as the auditor. Sampling sizes, observations, and interviews should give reasonable assurance that the evidence is valid;

b. Reliability: Seek the best documentation possible (e.g., is testimony corroborated by other evidence?); and

c. Relevance: The evidence must be linked to the area and must have a logical, sensible relationship to the issue.

4. Deficiencies: Auditors may investigate and report on any areas needing improvement. Deficiencies include but are not limited to:

a. Deviations from policies, regulations, or ACA standards;
b. Weaknesses in internal controls;
c. Lack of quality controls;
d. Failure to observe accepted standards or adhere to proven established procedures;
e. Lack of operating efficiency;
f. Failure to meet objectives; or
g. Perceived need for improvement in operations or programs.

5. Exemplars: Auditors may report on any significant solutions, successes, and strengths of operations or programs that are exemplary.

6. Serious or Unusual Problems: Should a serious situation or problem manifest itself, the chairperson may halt or redirect the focus of the audit.

Any evidence of fraud, waste, abuse, or illegal acts should be immediately reported to the Superintendent and appropriate Assistant Deputy Commissioner, Deputy Commissioner and Commissioner. Should the accusations involve the Superintendent, they should be reported directly to the appropriate Assistant Deputy Commissioner, Deputy Commissioner and Commissioner.

7. Working Papers: The auditors shall prepare a written record of the audit. The format may vary from time to time but shall usually include handwritten notes based upon interviews, observations, and review of documents (there may be computer printouts, logs, etc., any analysis or computations done, any reprinted checklists used, etc.)

The chairperson may collect all working papers and submit them along with the final written report, to the Director of the PDCU. The working papers may be destroyed after the written report is reviewed by the Director of the PDCU.

8. Interviews: There are three (3) types of interviews:

   a. Entrance: Upon arrival at the institution, the auditors shall meet with the Superintendent or designee and any key staff as determined by the Superintendent.

      The chairperson shall discuss the scope of the audit, describe how it shall be conducted and discuss the time frames, including the date and time of the final closeout.

   b. Discovery: The auditors may interview staff, incarcerated individuals and civil commitments. Auditors should strive to interview a representative sample for accuracy, however, they should be as unobtrusive as possible. The auditor should make it clear to the interviewee that notes may be taken.

   c. Close-out: The Superintendent shall be given the opportunity to be informed of all significant findings prior to the close-out. The closeout will include the audit team, the institution administration and extended/key institution staff members. The audit team will provide the institution administration and staff with the discrepancies noted in each of the operational areas assessed during the audit. Additionally, the audit team will also inform the institution staff of the positive outcomes identified throughout the audit process. If the status of a finding should change from that orally discussed with the Superintendent, the chairperson shall apprise the Superintendent prior to submitting the final written report.

C. <u>Evaluation</u>

1. Ongoing from the time of preparation to the time of submitting the final written report, the auditors evaluate the institution. The evaluation is based upon documents reviewed, interviews held, and observations made.

2. The criteria by which the institution is evaluated include, but are not limited to, the Massachusetts General Laws, Department

Regulations and policies, ACA standards, and institution procedures.

3. Auditors should look for patterns, trends, causes, and effects of perceived problems, or seek to identify innovative practices.

4. The evidence, as stated in 112.06 (B)(2), shall be collected into a series of findings. The findings shall consider the significance of the deficiency or exemplary, and whether or not it should be included in the final written report, handled informally (verbally), or overlooked.

5. Questions regarding the significance of an issue should be addressed to the chairperson.

    a. In determining the relative significance of a deficiency, the chairperson may be guided by the following:
        i. The extent of the problem or pervasiveness;
        ii. The risk to the affected operation or program area;
        iii. The importance of the operation or program to the institution's or Department's mission;
        iv. Indication of fraud, waste, abuse, illegal acts, or anything that might warrant adverse personnel action; or
        v. Dollar amount involved.

    b. In determining the significance of any exemplary, the following factors may be considered:
        i. Innovativeness;
        ii. Efficient, cost-effective use of resources;
        iii. Effectively targets a problem; or
        iv. Can be applied elsewhere.

6. Findings: The auditors shall provide an overall rating of each area assessed. One (1) of the following ratings shall be proposed for the areas audited:

    a. Good: The program is performing all its <u>vital functions</u> and there are few discrepancies within any function. Internal controls are effectively monitoring the performance of the program. Overall performance is above an acceptable level. Discrepancies have no material impact on the execution of the area's objectives.

    b. Improvement Needed: The <u>vital functions</u> are being performed adequately; however, numerous discrepancies

may exist. While there are internal controls monitoring the performance of the program, the discrepancies identified have the potential to impact the execution of the vital functions of the area.

c. Deficient: The discrepancies identified have significantly impacted the execution of one (1) or more vital function(s) of the area. There are insufficient internal monitoring controls in place.

Note: The vital functions of a given operation or program shall be determined by the Director of the PDCU or the chairperson.

7. Each rated finding should be substantiated. The commentary should be titled "Issue". Depending upon the circumstances, the auditors may structure their assessment by citing:

a. Conditions: State what was found, type of evidence used, extent of the problem, number of cases involved, etc.

b. Criteria: State what should be found according to policy, regulations, etc. Use precise citations where possible.

c. Effect: State what are the results or potential consequences of the existing condition.

d. Cause: Attempt to discern why the condition exists (i.e., training issue, a supervisory issue, etc.).

D. Reporting

1. A detailed, written report shall be prepared. The audit report shall include the date it was prepared, who participated as auditors (names, titles, usual place of work), a brief statement of the dates of the audit, names of the key personnel attending interviews or otherwise participating, discussion of recent events, findings from the previous audit, a summary of the specific areas covered, any responses to a Superintendent's or Assistant Deputy Commissioner's request for examination of particular areas, listing of significant repeat findings, i.e., those deficiencies noted in the previous report that remain deficient (whether for the same or different reasons), and detailed significant findings.

2. The auditors should place deficient or exemplary findings into perspective and be fair and accurate. Only that information that is adequately supported by sufficient evidence can be included.

3. The report shall be clear, concise, and the conclusions drawn should be specific and not left to inference. The information must be presented so as to persuade the reader of the appropriateness of the conclusion.

4. It is not necessary for the report to comment upon every component of a given area. Rather, for any given operation or program assessed, unless specified otherwise, the reader can assume that all of the components were assessed but that only those meriting mention are discussed.

5. The chairperson shall ensure that the findings are adequately supported by sufficient, reliable, and relevant evidence rather than by evidence of minor, irrelevant, or insignificant matters.

6. Timeliness and Distribution

   a. The chairperson has thirty (30) days from the close-out to submit a detailed, written report of the audit findings. Therefore, the auditors must submit to the chairperson their sections for inclusion shortly after the closeout.

   b. The chairperson submits a written report to the Director of the PDCU.

   c. The Director of the PDCU shall review the report and forward it to the Commissioner with copies to the appropriate Deputy Commissioner and Assistant Deputy Commissioner within forty-five (45) days from the date of the closeout.

   d. The Commissioner shall review the report and, within thirty (30) days from receiving the report, send the affected Superintendent a copy of the audit report along with a memorandum discussing the results and requesting that the Superintendent respond, in writing, within forty-five (45) days to the Director of the PDCU. Copies of the Commissioner's memorandum shall be sent to the appropriate Deputy Commissioner, Assistant Deputy Commissioner, and the Director of the PDCU.

   e. Upon receipt of the Commissioner's memorandum and the audit report, the Superintendent shall have forty-five (45) days to review and submit a plan of action through PowerDMS. The Superintendent may contest the findings

or may submit a plan of action. A plan of action must include:

i. Corrective Action: a description of what action is needed to correct the issue and prevent its future recurrence.
ii. Staff responsible: identify all staff responsible for implementation and monitoring the corrective action.
iii. Status: indicates the anticipated target date or completion date when the corrective action takes effect.

A plan of action shall also include physical plant comments that relate to tool accountability, life, fire and/or safety issues, etc., in addition to observations noted that can be permanently corrected. In these instances, a plan of action shall also be included in the audit response.

f. Once the plan of action has been developed, the Superintendent shall notify the Director of the PDCU, who will then schedule the Corrective Action Meeting which will include the Superintendent, Deputy Superintendent(s), members of the audit team, and Department Executive Staff. In this meeting, the Superintendent shall present their plan of action for the vital areas of concern outlined in the audit report.

g. At the conclusion of the Corrective Action Meeting, the Superintendent shall make any necessary revisions to the plan of action, via PowerDMS, to the Director of the PDCU within thirty (30) days.

h. The Director of the PDCU will have sixty (60) days from the date of receipt of the Superintendent's response to review the plan of action and schedule the follow-up audit.

E. Audit Report Follow-Up

1. Within sixty (60) days of the receiving the institution’s plan of action, the Director of the PDCU shall conduct a follow-up audit to reassess the vital areas of concern that were addressed during the Corrective Action Meeting. The length of the follow-up audit shall be determined by the Director of the PDCU who shall notify the Superintendent of the audit schedule.

2. The Superintendent shall ensure that key staff members are available for the vital areas being reassessed for the duration of the follow-up audit. Within thirty (30) days of the follow-up audit, the Director of PDCU shall generate a final written report detailing the findings of the follow-up audit to the Commissioner.

3. Within thirty (30) days from receipt of the final report, the Commissioner shall send the affected Superintendent a copy of the audit report along with a memorandum discussing the results and closing out the audit process.

4. Outside Distribution: Parties not within the established distribution chain described in the previous section may direct requests for copies of audit reports, working papers, and responses to the Commissioner.

112.07 INSTITUTION ACCREDITATION PROCESS

This section shall provide a framework for establishing an efficient system of data collection and data quality review.

A. Data Collection Periods

The institution's supporting documentation shall be collected from audit to audit. For example, an institution undergoing it's ACA audit in March of 2027 shall have documentation covering the following time frames:

April 2024 to March 2025
April 2025 to March 2026
April 2026 to March 2027

Once this time frame has been established, it must be adhered to throughout the three (3) years of the accreditation cycle.

B. Data Collection Methods

Each Superintendent shall be responsible to establish practice for ACA data collection based upon the following guidelines:

1. Each institution shall establish a system by which responsibility for collecting ACA documentation is disseminated from upper management through line supervisors. The system by which this is accomplished shall include at a minimum, but not be limited to the following:

a. Data collection shall start immediately following the institution's ACA audit and continue throughout the three (3) years. Documentation for the third year of the accreditation cycle shall be collected as close to the institution's scheduled pre-ACA audit as possible.

b. Typically, documentation shall be gathered to show one (1) sample of a given action for each year of the accreditation period. When a standard calls for daily, weekly, or monthly examples, two (2) consecutive documents shall be used.

c. If a memo to the standard is required (e.g., if there were no uses of force for that collection period), it shall be documented as a simple note in the electronic ACA assessment for the applicable year of the accreditation cycle.

2. An ACA steering committee, comprised of the institution ACA Coordinator and three (3) to five (5) other members ranging from senior staff to line staff, must meet at least monthly. The monthly meeting shall be documented, in writing, with the committee members in attendance noted and meeting minutes detailed. The minutes shall be maintained for all three (3) years of the accreditation cycle.

a. The steering committee, through the Superintendent, shall issue a memorandum each year of the accreditation period directing department heads to begin the data collection process for a particular time period (i.e., April 2025 to March 2026, etc.). The memorandum shall inform the individual department head of all the ACA standards they are required to collect documentation for and the time frame by which the documentation is to be submitted (e.g., three (3) months from the receipt of the memo, etc.). Department heads shall be ultimately responsible for the collection of the data assigned to them. However, the task of collecting the data should be disseminated to supervisors and staff members in the department head's area. In this way, the ACA process will involve all levels of institution staff.

b. Specific directions shall be attached to these memorandums indicating what information is required for each standard. Information should be disseminated in either a working

folder or through an electronic distribution method. For institutions utilizing an electronic distribution method, Superintendents shall develop procedures for the dissemination of the memorandums along with the standard language and the documentation required to substantiate the standard.

C. Data Quality

1. Once the documentation has been gathered, it shall be forwarded to the ACA steering committee for data quality checks prior to being uploaded into the electronic assessment. The committee shall ensure that all documentation gathered is complete, accurate, and appropriate for inclusion into the electronic assessment.

2. The institution ACA Coordinator shall ensure that the electronic assessment is maintained in an audit ready format throughout each year of the accreditation cycle. Documentation received from department heads shall be uploaded into the assessment as it is received and highlighted appropriately within the system. Applicable policies and procedures shall be appropriately highlighted. As policies and procedures are reviewed and updated, the ACA Coordinator shall ensure the highlighted area(s) are accurate.

3. The ACA Coordinator shall be responsible for tracking the return of the working folders if the institution continues to utilize them outside of the electronic assessment. For institutions not utilizing working folders, the ACA Coordinator shall be responsible for developing and implementing a tracking system for the return of the required documentation from each department head. At a minimum, the tracking system shall document the following:

   a. Which department head each working folder/standard was assigned to data collection.
   b. The deadline that was established for documentation to be returned.
   c. When the documentation was returned and if the section for the working folder has been completed, and/or documentation that remains outstanding.

4. At the end of each data collection period, the ACA Coordinator and the steering committee shall issue a report to the Superintendent identifying any working folders/electronic assessment standards that have not been returned, as well as the status of the entire process.

5. Standard outcome measures shall be compiled from month to month for each year of the accreditation cycle. The collection of the outcome measures begins on the month prior to the accreditation cycle (e.g. If the institution's accreditation cycle is February through January, the outcome measures are collected January through December). The department heads/designee(s) are responsible for compiling their respective outcome measure data and forwarding the data to the ACA Coordinator. Healthcare outcome measures shall be compiled by the Health Services Administrator (HSA). At the end of each accreditation year, the ACA Coordinator shall ensure that the outcome measure statistics are compiled on the proper form and available for review for the proper time frame (audit to audit). This information must also be included in the annual report due on the anniversary of the institution's ACA audit, as well as the next consecutive year.

6. ACA significant incident summaries and outcome measures shall be completed for each year of the accreditation cycle for submission to ACA. The final year, or third (3rd) year of the accreditation cycle, shall be given to the auditors at the time of the re-accreditation audit.

   Note: A copy of the annual significant incident summary report and the outcome measures shall be submitted, along with the ACA annual report, through the Director of the PDCU for review/approval before it is submitted to ACA annually (excluding the year of the institution's panel hearing).

D. Periodic Assessment Reviews

1. During the institution's three (3) year accreditation cycle, PDCU will conduct periodic ACA assessment audits to gauge the rate of progress and determine the level of compliance for the mandatory and non-mandatory standards. A written report detailing the standards assessed and any recommendations will be generated by the Director of the PDCU and submitted to the Superintendent.

2. During a pre-ACA audit, a plan of action audit response relating to each standard is not necessary, unless the recommendations are not being followed, and in that case, justification on why must be included within the plan of action response. If budget or other issues preclude resolution, an explanation should be provided.

E. Performance Monitoring Visits

1. ACA will conduct performance monitoring visits between twelve (12) and eighteen (18) months from the date of the institution's last ACA re-accreditation audit.

2. ACA will notify the Department two (2) weeks prior of their intent to conduct a performance monitoring visit.

Audit Process Flow Chart

Pre-Audit Preparation	
January	Superintendent notified of the upcoming fiscal year audit schedule with the anticipated month of audit
30 Days Prior	Superintendent notified of the official audit dates

Audit	
Daily	Audit Team will meet with the Institution's Administration
Final Audit Day	Initial Closeout with Audit Team, Institution Administration, and Respective Assistant Deputy Commissioner (ADC)

Audit Report	
Thirty (30) days from the initial closeout	The Audit Chairperson shall submit a detailed Audit Report to the Director of the PDCU
Forty-five (45) days from the initial closeout	The Director of the PDCU will review the Audit Report and submit to the Commissioner
Thirty (30) days from receipt of the report	The Commissioner shall review Audit Report and submit to the Superintendent along with a memorandum for a Plan of Action for all issues noted
Forty-five (45) days from receipt of the report	Superintendent shall submit a Plan of Action for all issued noted on the Audit Report to the Director of the PDCU through PowerDMS
Upon Receipt of Plan of Action	The Director of the PDCU will schedule a Corrective Action Meeting with Executive Staff, Institution Administration, and the Audit Team
Thirty (30) days from the Corrective Action Meeting	The Superintendent shall amend the Plan of Action, if necessary, via PowerDMS

Follow-Up Audit	
Sixty (60) days from receipt of final Plan of Action	Follow-up Audit to be scheduled by the Director of the PDCU within sixty (60) days of receipt of the institution's final Plan of Action.

Final Report	
Thirty (30) days after follow-up audit	Final Report shall be submitted by the Director of the PDCU to the Commissioner
Thirty (30) days from Receipt of Final Report	The Commissioner shall review the Final Report and submit it to the Superintendent. This ends the audit process.