PREA Facility Audit Report: Final

Name of Facility: The Open Hearth Residential Program
Facility Type: Community Confinement
Date Interim Report Submitted: NA
Date Final Report Submitted: 07/22/2022

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	☑
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Latera M. Davis	**Date of Signature:** 07/22/2022

AUDITOR INFORMATION	
Auditor name:	Davis, Latera
Email:	lateradavis@djj.state.ga.us
Start Date of On-Site Audit:	06/01/2022
End Date of On-Site Audit:	06/02/2022

FACILITY INFORMATION	
Facility name:	The Open Hearth Residential Program
Facility physical address:	150 Charter Oak Avenue , Hartford , Connecticut - 06106
Facility mailing address:	150 Charter Oak Ave, Hartford, Connecticut - 06106-5102

Primary Contact	
Name:	Fred Faulkner
Email Address:	ffaulkner@theopenhearth.org
Telephone Number:	860-257-5571

Facility Director	
Name:	Fred Faulkner
Email Address:	ffaulkner@theopenhearth.org
Telephone Number:	860-257-5571

Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	

Facility Characteristics	
Designed facility capacity:	44
Current population of facility:	32
Average daily population for the past 12 months:	33
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	18+
Facility security levels/resident custody levels:	Community Release
Number of staff currently employed at the facility who may have contact with residents:	29
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Open Hearth Association, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	150 Charter Oak Avenue , Hartford , Connecticut - 06106
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	
Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	Fred Faulkner	**Email Address:**	ffaulkner@theopenhearth.org

SUMMARY OF AUDIT FINDINGS	
The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met. Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.	
Number of standards exceeded:	
0	
Number of standards met:	
41	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2022-06-01
2. End date of the onsite portion of the audit:	2022-06-02

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	◉ Yes ○ No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	JDI-email correspondence YWCA-attempting several phone calls-no responses.

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	44
15. Average daily population for the past 12 months:	31
16. Number of inmate/resident/detainee housing units:	2
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	○ Yes ○ No ◉ Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit

Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit

36. Enter the total number of inmates/residents/detainees in the facility as of the first day of onsite portion of the audit:	40
38. Enter the total number of inmates/residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
39. Enter the total number of inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	1
40. Enter the total number of inmates/residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0

41. Enter the total number of inmates/residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
42. Enter the total number of inmates/residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
43. Enter the total number of inmates/residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	0
44. Enter the total number of inmates/residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
45. Enter the total number of inmates/residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
46. Enter the total number of inmates/residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	2
47. Enter the total number of inmates/residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
48. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	No text provided.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
49. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	33
50. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
51. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
52. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	No text provided.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	8
54. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☐ Gender ☐ Other ☐ None
55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	It should be noted that 10 residents were interviewed using the random interview protocol however 2 residents were also interviewed as targeted residents.
56. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	◉ Yes ○ No
57. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	It should be noted that 10 residents were interviewed using the random interview protocol however 2 residents were also interviewed as targeted residents.
Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	2
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
60. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	1
61. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	1

62. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As reported by the facility and during file review and interview with residents the targeted group was not identified.
63. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As reported by the facility and during file review and interview with residents the targeted group was not identified.
64. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As reported by the facility and during file review and interview with residents the targeted group was not identified.

65. Enter the total number of interviews conducted with inmates/residents/detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As reported by the facility and during file review and interview with residents the targeted group was not identified.
66. Enter the total number of interviews conducted with inmates/residents/detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As reported by the facility and during file review and interview with residents the targeted group was not identified.
67. Enter the total number of interviews conducted with inmates/residents/detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As reported by the facility and during file review and interview with residents the targeted group was not identified.

68. Enter the total number of interviews conducted with inmates/residents/detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As reported by the facility and during file review and interview with residents the targeted group was not identified.
69. Enter the total number of interviews conducted with inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As reported by the facility and during file review and interview with residents the targeted group was not identified.
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	All targeted residents identified at the facility were interviewed.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

71. Enter the total number of RANDOM STAFF who were interviewed:	12

72. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	The random staff were interviewed based on their position, tenure, and staff schedule. All shifts were interviewed.

Specialized Staff, Volunteers, and Contractor Interviews

Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.

75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	24
76. Were you able to interview the Agency Head?	◉ Yes ○ No
77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	◉ Yes ○ No
78. Were you able to interview the PREA Coordinator?	◉ Yes ○ No
79. Were you able to interview the PREA Compliance Manager?	○ Yes ○ No ◉ NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

80. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☑ Agency contract administrator ☐ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☐ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☑ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff ☐ Other
81. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?	○ Yes ◉ No
82. Did you interview CONTRACTORS who may have contact with inmates/residents/detainees in this facility?	○ Yes ◉ No
83. Provide any additional comments regarding selecting or interviewing specialized staff.	The facility reported that there were no volunteer or contracted staff.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

84. Did you have access to all areas of the facility?	(•) Yes ( ) No
Was the site review an active, inquiring process that included the following:	
85. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(•) Yes ( ) No
86. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(•) Yes ( ) No
87. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	(•) Yes ( ) No
88. Informal conversations with staff during the site review (encouraged, not required)?	(•) Yes ( ) No
89. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	During the inspection of the physical plant the auditor and was escorted throughout the site by the program unit manager. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred or deterred entry to any areas. The auditor had the ability to freely observe, with entry provided to all areas without prohibition. Based on review of documentation the site is compliant with the intent of the provision.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

90. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(•) Yes ( ) No
91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	During the on-site visit, the auditor was provided access to all documents requested. All documents requested were received to include, but not limited to employee and resident files, sensitive documents, and investigation reports. Based on review of documentation the site is compliant with the intent of the provision.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

92. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

93. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

94. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

95. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

96. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

97. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:	0
a. Explain why you were unable to review any sexual abuse investigation files:	N/A there were zero reported allegations of sexual abuse or sexual harassment.

99. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
101. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
102. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
104. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
105. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. Explain why you were unable to review any sexual harassment investigation files:	N/A there were zero reported allegations of sexual abuse or sexual harassment.

107. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
109. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
110. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
112. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
113. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	N/A there were zero reported allegations of sexual abuse or sexual harassment.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

115. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff

116. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

AUDITING ARRANGEMENTS AND COMPENSATION

121. Who paid you to conduct this audit?	○ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ◉ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other
Identify the name of the third-party auditing entity	Diversified Correctional Services

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Open Hearth Mission Our mission is to help men experiencing homelessness enhance their capacity for self-help, self-respect, and dignity, and to achieve their full potential as responsible citizens of Greater Hartford and Connecticut. The Open Hearth is a 40-bed community-based work residential recovery and work therapy program located in Hartford Connecticut. Men are placed into this program for work-readiness as they transition out of “incarceration” and back into full participation in the community. At the successful completion of the program men may seek (and achieve) placement in the Open-Hearth Transitional Living Program. The program is contracted to the Connecticut Department of Corrections. The Open Hearth was founded in 1884 by members of St. John’s Guild of Christ Church as a reading room that opened four nights a week. The purpose of The Hearth was to offer men a place to meet, read and socialize, as a means to avoid the social ills of that time. A few years after its founding, the organization began housing men who had no place to live. The Open Hearth was one of the first organizations in the country to begin what today might be called social enterprise, operating a wood yard, a chair-caning business, and a working farm. By 1927, to meet the ever-increasing need for housing and jobs. The Hearth purchased a four-story brick building at 150 Charter Oak Avenue in Hartford. During the Great Depression, The Hearth was home to thousands of men. When there were no beds available, men slept upright in chairs in the reading room or on the floor in the parlor. In 1991, the building was expanded and rebuilt. Since its inception, The Hearth’s understanding of the challenges facing these truly disenfranchised mends has evolved and deepened. It can shelter, counsel and feed as many as 107 clients each day. The 35,000 square feet Open Hearth building is located Southeast of downtown in Hartford Connecticut. The original building was constructed in 1927 with a major addition constructed in 1992. It has four floors. The first floor consists of common areas; the second floor contains staff offices and the shelter; and the third and fourth floors are the residential living floors. The third floor is the residential floor for the Connecticut Department of Corrections halfway house and is divided into two wings. The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Zero Tolerance Organization Chart REA Postings (English/Spanish) Updated Policy Interviews: PREA Coordinator Findings (By Provision): 115.211(a). As reported in the PAQ, the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility has a written policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. Policy: The Zero Tolerance policy states that “The Open Hearth has a zero tolerance for any acts of sexual abuse, assault, misconduct or harassment. Sexual activity between staff, volunteers or contracted personnel and clients, as well as between client and client is prohibited and subject to administrative and criminal disciplinary sanctions. The Open-Hearth staff shall take prudent measures to ensure the safety of both clients and staff. All employees, contractors, volunteers and clients shall have a clear understanding that a sexual relationship with an individual under the CTDOC supervision is strictly prohibited and is a serious breach of employee conduct. All contracts with providers shall include the contracting entity’s obligation to adopt and comply with the PREA standards outlined in FDJJ policy 1919. Contracted providers will be subject to PREA audits, including contract monitoring to ensure compliance”.

Corrective Action: An updated was made to the policy to add “Staff found not consistent with this policy will face disciplinary action up to, and possibly including termination”.

Documentation Reviewed

PREA Postings (English/Spanish)

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.211(b). As reported in the PAQ, the agency employs or designates an upper-level, agency-side PREA coordinator. It was further reported that PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. The position of the PREA Coordinator directly reports to the agency CEO.

Documents Reviewed

Organizational Chart

Interviews

PREA Coordinator – The interviewed staff reported that they have enough time to manage all of their PREA related responsibilities. At The Open Hearth (TOH) the safety of the men in general, and compliance with PREA protocols in particular, makes my PREA related responsibilities a priority. Because it is a priority, I have the support of my superior in implementing my PREA related activities. The staff further reported that perhaps my most important job is to create and foster a culture in which there is openness and understanding. In terms of openness, that the men in our care know that my door is open to them at all times to discuss any concerns or issues they may have. In a culture such as our men should not be hesitant to share concerns, they have that are PREA related or otherwise. In terms of understanding, the staff are aware that we should be sensitive and responsive to the special needs of men. As an example, recently we had a man who, due to gender identity related issues, felt uncomfortable showering in the main bathroom. Without hesitation or questioning arrangements were made for the man to shower privately elsewhere in the facility. I make a concerted effort to foster this culture and make sure that all (staff and residents) are aware of it.

If an issue with complying with a PREA standards is identified the course of action taken depends on the issue but my immediate inclination would be to communicate the concern to my superior and then assemble the appropriate staff to attempt resolution. If after consultation with my superior and staff I determined that the issue were not resolved appropriately, I would seek assistance from CTDOC.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion

115.211. An update to the policy was made.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.212	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

The following evidence was analyzed in making compliance determination:

Supporting Documents, Interviews and Observations:

Pre-Audit Questionnaire (PAQ)

Policy: Zero Tolerance

DOC Contract

Interviews:

Agency Contract Administrator

Findings (By Provision):

115.212 (a). As reported in the PAQ, the agency has entered or renewed any contract for the confinement of residents. After further review it was determined that FHM is the contracted provider for the Connecticut Department of Corrections. They do no have a contract with another entity house their residents.

The number of contracts for the confinement of residents that the agency entered into or renewed with private entities or other government agencies on or after August 20, 2012, or since the last PREA audit, whichever is later: 1.

The number of above contracts that DID NOT require contractors to adopt and comply with PREA standards: 0.

Documentation Reviewed

DOC Contract

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.212 (b). As reported in the PAQ, the agency has entered or renewed any contract for the confinement of residents. After further review it was determined that FHM is the contracted provider for the Connecticut Department of Corrections. They do no have a contract with another entity house their residents.

The number of contracts referenced in 115.212 (a)-3 that DO NOT require the agency to monitor contractor's compliance with PREA standards: 0.

Interviews

Agency Contract Administrator – The interviewed contract administrator reported that the only contract the program has is to provide services for the supervision of men under the Department of Corrections supervision. The program does not contract with an outside agency to provide services on its behalf.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.212(c). As reported in the PAQ, the agency has not entered into one or more contracts with a private agency or other entity that failed to comply with the PREA standards.

Agency Contract Administrator – The interviewed contract administrator reported that the only contract the program has is to provide services for the supervision of men under the Department of Corrections supervision. The program does not contract with an outside agency to provide services on its behalf.

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.213	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Zero Tolerance DOC Contract Interviews: Agency Contract Administrator Findings (By Provision): 115.212 (a). As reported in the PAQ, the agency has entered or renewed any contract for the confinement of residents. After further review it was determined that FHM is the contracted provider for the Connecticut Department of Corrections. They do no have a contract with another entity house their residents. The number of contracts for the confinement of residents that the agency entered into or renewed with private entities or other government agencies on or after August 20, 2012, or since the last PREA audit, whichever is later: 1. The number of above contracts that DID NOT require contractors to adopt and comply with PREA standards: 0. Documentation Reviewed DOC Contract Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.212 (b). As reported in the PAQ, the agency has entered or renewed any contract for the confinement of residents. After further review it was determined that FHM is the contracted provider for the Connecticut Department of Corrections. They do not have a contract with another entity house their residents. The number of contracts referenced in 115.212 (a)-3 that DO NOT require the agency to monitor contractor's compliance with PREA standards: 0. Interviews Agency Contract Administrator – The interviewed contract administrator reported that the only contract the program has is to provide services for the supervision of men under the Department of Corrections supervision. The program does not contract with an outside agency to provide services on its behalf. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.212(c). As reported in the PAQ, the agency has not entered into one or more contracts with a private agency or other entity that failed to comply with the PREA standards. Agency Contract Administrator – The interviewed contract administrator reported that the only contract the program has is to provide services for the supervision of men under the Department of Corrections supervision. The program does not contract with an outside agency to provide services on its behalf. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.215	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Zero Tolerance Pat Frisk Search Training (12) Interviews: Resident Interview Questionnaire (10) Random Sample of Staff (12) Findings (By Provision): 115.215 (a). As reported in the PAQ, the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. Policy: The Zero Tolerance policy states that “The Open-Hearth facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches”. In the past 12 months, the number of cross-gender strip or cross-gender visual body cavity searches of residents: 0 In the past 12 months, the number of cross-gender strip or cross-gender visual body cavity searches of residents that did not involve exigent circumstances or were performed by non-medical staff: 0 Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.215 (b). NA-the facility houses male residents. 115.215 (c). As reported in the PAQ, the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. 115.215 (d). As reported in the PAQ, the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. Policy: The Zero Tolerance policy states that “Residents will be able to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing their breasts, buttocks, or genitalia. Staff of the opposite gender must announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing”. Interviews Resident Interview Questionnaire – All of the interviewed residents reported that female staff announce their presence when entering the housing area. The residents reported that the staff will knock before entering an area. All of the interviewed residents reported that they are never naked in full view of opposite gender staff. Several of the residents further stated that the female staff are good at knocking on the door and letting them know if they need to come into the area. Random Sample of Staff: The interviewed staff were consistent in their response that staff announce their presence when entering a housing unit that houses resident of the opposite gender. After probing interviewed staff, each consistently gave similar examples of what is stated when entering the housing unit of the opposite gender. All of the staff reported that residents able to dress, shower, and use the toilet without being viewed by staff of the opposite gender. PREA Audit Site Review: During the tour, staff made announced as I walked through the center. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the

facility is in compliance with the provisions of this standard.:

115.215 (e). As reported in the PAQ, the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. There were zero reported searches that occurred in the last 12 months.

Policy: The Zero Tolerance policy states that "The Open-Hearth Staff shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's gender status is unknown, it may be determined during conversations with the resident or by reviewing medical records".

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.215 (f). As reported in the PAQ, 0% of staff who have received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional manner with security needs. After conducting the onsite audit and interviews of staff, it was determined that some staff have receive pat frisk search training in the last year. While the facility does not allow for cross-gender searches, 12 staff completed pat frisk search training. It was also determined that not all direct care staff are trained at this time to conduct pat risk searches.

Documentation Reviewed

Pat Frisk Search Training Log (12)

Interviews

Random Sample of Staff: The interviewed staff were consistent in their response that staff announce their presence when entering a housing unit that houses resident of the opposite gender. After probing interviewed staff, each consistently gave similar examples of what is stated when entering the housing unit of the opposite gender. All of the staff reported that residents able to dress, shower, and use the toilet without being viewed by staff of the opposite gender.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.216	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act (PREA) Memo: Interpreter Services Interviews: Agency Head Residents (with disabilities or who are limited English proficient) Random Sample of Staff (12) Disabled and Limited English Proficient Residents (2) Findings (By Provision): 115.216 (a). As reported in the PAQ, the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Policy: The Zero Tolerance policy states that "The Open Hearth shall take appropriate steps to ensure that residents with disabilities (Including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary, steps to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision". The agency/facility does not have a contract for interpretation services however utilizes the services within the community and provided to the court. A quick link to those services is www.jud.ct.gov/ADA/default.htm. Interviews Agency Head – The interviewed staff reported that TOH does not have blind, deaf or non-ambulatory residents. We do address the special circumstance of residents who are not English dominant. Our publications (posters, signs, brochures) are all bilingual. English and Spanish. Except under emergency circumstances, we do not use resident interpreters to translate for clients in significant circumstances. Residents (with disabilities or who are limited English proficient) – The interviewed resident reported that the facility provided them information in a manner in which they were able to understand. The resident stated that they read the information to him and asked if he could understand the information. The resident further reported that he could understand the information and could recall if they gave me copies of the information. PREA Audit Site Review: During the onsite inspection the auditor observed written material available for residents in Spanish and English; along with information for interpreter services. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.216 (b). As reported in the PAQ, the agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse or sexual harassment. Policy: The Zero Tolerance policy states that "The Open Hearth shall take reasonable steps to ensure meaningful access to

all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary".

The agency provided a memo stating that in addition to having Spanish speaking staff, the Open Health has access to interpretation services provided by:

· Hartford Public Library Language Line

· State of Connecticut, Judicial Branch, Interpreter and Translator Services Unit

Documentation Reviewed

Memo: Interpreter Services

Interviews

Residents (with disabilities or who are limited English proficient) – The interviewed residents reported that the facility provided them information in a manner in which they were able to understand. The residents further stated that staff read the information to them and asked if they could understand the information. The residents further reported that they could understand the information and could recall that they were provided written documentation.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.216 (c). As reported in the PAQ, the agency policies prohibit other use of resident interpreters, resident readers, or other type of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties, or the investigation of the residents' allegations. Furthermore, the agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used.

In the past 12 months, the number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations: 0.

Policy: The Zero Tolerance policy states that "The Open Hearth shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the residents safety".

The agency provided a memo stating that in addition to having Spanish speaking staff, the Open Health has access to interpretation services provided by:

· Hartford Public Library Language Line

· State of Connecticut, Judicial Branch, Interpreter and Translator Services Unit

Documentation Reviewed

Memo: Interpreter Services

Interviews

Random Sample of Staff: The interviewed random sample of staff reported that they do not allow the use of resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. Several staff reported that they would get an interpreter if one was needed. Staff reported they do not have any residents that would need use of a resident interpreter, resident reader, or any type of resident assistant.

Residents (with disabilities or who are limited English proficient) – The interviewed residents reported that the facility provided them information in a manner in which they were able to understand. The residents further stated that staff read the information to them and asked if they could understand the information. The residents further reported that they could understand the information and could recall that they were provided written documentation.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion:

	A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.217	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Hiring and Promotion Decisions Personnel Files · Application (9 New Hire) · Background Checks (31) · Pre-employment Questionnaire (9 New Hire) · 5-year background check (9) Memo: Employee Reference Checks (2) Memo: Background Checks Interviews: Administrative (Human Resources) Staff Findings (By Provision): 115.217 (a). As reported in the PAQ, the agency policy does not prohibit hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who: 1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution. 2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or 3. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2). Policy: The Hiring and Promotion Decisions policy states that: “The Open Hearth shall not hire anyone who may have contact with inmates who is known to have: 1. Engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, institution housing persons who are mentally ill or disabled or retarded or chronically ill or handicapped, or institution providing skilled nursing or intermediate or long-term care or custodial or residential care; 2. Been convicted of engaging in or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or 3. Was civilly or administratively adjudicated to have engaged in the activity described in subsection (2) of this section. The Open Hearth shall consider any known incidents of sexual abuse/harassment in determining whether to hire anyone who may have contact with clients. Before hiring new employees, who may have contact with clients, The Open Hearth shall: 1. Perform a criminal background check and 2. Consistent with Federal, State and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of resident or detainee sexual abuse/harassment or any resignation pending an investigation of such allegations. 3. Ask the applicant in a written application or interview directly about whether they have been found to have engaged in sexual abuse/ harassment in a prison, jail, lockup, community confinement facility, juvenile facility, institution housing persons who are mentally ill or disabled or retarded or chronically ill or handicapped, or institution providing skilled nursing or

intermediate or long-term care or custodial or residential care. Material omissions regarding such misconduct or the provision of materially false information regarding such misconduct may be grounds for termination".

Documentation Reviewed

Personal Files/Background Checks (31)

Memo: Background Checks

Interviews

Discussion: The auditor reviewed the background checks of new hires and existing staff.

115.217 (b). As reported in the PAQ, the agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

Policy: The Hiring and Promotion Decisions policy states that:

"The Open Hearth shall not hire anyone who may have contact with inmates who is known to have:

1. Engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, institution housing persons who are mentally ill or disabled or retarded or chronically ill or handicapped, or institution providing skilled nursing or intermediate or long-term care or custodial or residential care;

2. Been convicted of engaging in or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or

3. Was civilly or administratively adjudicated to have engaged in the activity described in subsection (2) of this section.

The Open Hearth shall consider any known incidents of sexual abuse/harassment in determining whether to hire anyone who may have contact with clients. Before hiring new employees, who may have contact with clients, The Open Hearth shall:

1. Perform a criminal background check and

2. Consistent with Federal, State and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of resident or detainee sexual abuse/harassment or any resignation pending an investigation of such allegations.

3. Ask the applicant in a written application or interview directly about whether they have been found to have engaged in sexual abuse/ harassment in a prison, jail, lockup, community confinement facility, juvenile facility, institution housing persons who are mentally ill or disabled or retarded or chronically ill or handicapped, or institution providing skilled nursing or intermediate or long-term care or custodial or residential care. Material omissions regarding such misconduct or the provision of materially false information regarding such misconduct may be grounds for termination".

The policy further states that:

The Open Hearth shall not promote any employee who may have contact with residents who is known to have:

1. Engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, institution housing persons who are mentally ill or disabled or retarded or chronically ill or handicapped, or institution providing skilled nursing or intermediate or long-term care or custodial or residential care;

2. Been convicted of engaging in or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or

3. Was civilly or administratively adjudicated to have engaged in the activity described in this section.

4. The Open Hearth shall consider any incidents of client sexual harassment in determining whether to promote anyone who may have contact with clients. In addition, The Open Hearth shall ask the candidate for promotion in a written application or interview directly about whether they have been found to have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, institution housing persons who are mentally ill or disabled or retarded or chronically ill or handicapped, or institution providing skilled nursing or intermediate or long-term care or custodial or residential care. Material omissions regarding such misconduct or the provision of materially false information regarding such misconduct may be grounds for termination.

Interviews

Administrative (Human Resources) Staff – The interviewed staff reported that the facility does not consider prior incidents of

sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. It was further reported that contracted staff do not have contact with residents without staff supervision.

Corrective Action: While the facility did not report any identified contracted staff the auditor notified the facility that the requirement for a background check is related to having contact and/or providing a service not have unsupervised contact; therefore, all contracted staff providing services to residents shall have a background check. The facility director shall issue a directive or establish a process that all volunteers and contractors providing services to residents are background checked. The directive was issued to the Director of Administration indicating that "consistent with PREA standards, commencing immediately all volunteers and contractors providing services to residents are to be background checked" No further action is needed.

115.217 (c). As reported in the PAQ, the agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

In the past 12 months, the number of persons hired who may have contact with residents who have had criminal background record checks: 9.

Policy: The Hiring and Promotion Decisions policy states that:

“The Open Hearth shall not hire anyone who may have contact with inmates who is known to have:

1. Engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, institution housing persons who are mentally ill or disabled or retarded or chronically ill or handicapped, or institution providing skilled nursing or intermediate or long-term care or custodial or residential care;

2. Been convicted of engaging in or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or

3. Was civilly or administratively adjudicated to have engaged in the activity described in subsection (2) of this section.

The Open Hearth shall consider any known incidents of sexual abuse/harassment in determining whether to hire anyone who may have contact with clients. Before hiring new employees, who may have contact with clients, The Open Hearth shall:

1. Perform a criminal background check and

2. Consistent with Federal, State and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of resident or detainee sexual abuse/harassment or any resignation pending an investigation of such allegations.

3. Ask the applicant in a written application or interview directly about whether they have been found to have engaged in sexual abuse/ harassment in a prison, jail, lockup, community confinement facility, juvenile facility, institution housing persons who are mentally ill or disabled or retarded or chronically ill or handicapped, or institution providing skilled nursing or intermediate or long-term care or custodial or residential care. Material omissions regarding such misconduct or the provision of materially false information regarding such misconduct may be grounds for termination”.

The facility director provided a memo stating that “it is my experience that attempting reference checks from institutional employers is a fruitless endeavor in Connecticut. Consistently, when we have contacted institutional employers, they will only provide start and termination dates with no further information”.

Documentation Reviewed

Personnel hired in the last 12 months

Memo: Contacting prior institutional employers

Memo: Reference Checks

Interviews

Administration (Human Resources Staff): The interviewed staff reported that criminal background checks are conducted on all new hire employees whether they have contact with residents or not. This is not done on contractors who have contact with residents as they do not have unsupervised contact.

Corrective Action: While the facility did not report any identified contracted staff the auditor notified the facility that the requirement for a background check is related to having contact and/or providing a service not have unsupervised contact;

therefore, all contracted staff providing services to residents shall have a background check. It is further recommended that the facility attempt to conduct the reference checks and document that there is not a response from the prior instructional employer. The facility director shall issue a directive or establish a process that all volunteers and contractors providing services to residents are background checked. The directive was issued to the Director of Administration indicating that "consistent with PREA standards, commencing immediately all volunteers and contractors providing services to residents are to be background checked".

An additional directive was issued stated that "consistent with PREA standards, commencing immediately a reference check should be performed on all employment applicants with their prior institutional employer. The results of the injury should be documented in the applicant's personnel file. The hiring supervisor would be responsible for conducting the check. Please modify our current application to provide a space to document the inquiry". No further action is needed.

115.217 (d). As reported in the PAQ, the agency policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. In the past 12 months, the number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 0.

During the documentation review phase, it was determined that the agency did not have policy language to address the provision. During the onsite phase, the agency immediately updated its policy to reflect the requirements of the provision.

Policy Update: The Hiring and Promotion Decisions Policy states that “TOH requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents”.

Documentation Reviewed

Memo: Background Checks

Interviews

Administration (Human Resources Staff): The interviewed staff reported that criminal background checks are conducted on all new hire employees whether they have contact with residents or not. This is not done on contractors who have contact with residents as they do not have unsupervised contact.

Corrective Action: While the facility did not report any identified contracted staff the auditor notified the facility that the requirement for a background check is related to having contact and/or providing a service not have unsupervised contact; therefore, all contracted staff providing services to residents shall have a background check. The facility director shall issue a directive or establish a process that all volunteers and contractors providing services to residents are background checked. The directive was issued to the Director of Administration indicating that "consistent with PREA standards, commencing immediately all volunteers and contractors providing services to residents are to be background checked". No further action is needed.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.217 (e). As reported in the PAQ, the agency policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents, or who may have contact with residents, or that a system is in place for otherwise capturing such information for current employees.

Policy: The Hiring and Promotion Decisions policy states that “The Open Hearth shall also perform a criminal background record check at least every five years of current employees”

Documentation Reviewed

5- Year Background Checks (9)

Interviews

Administration (Human Resources Staff): The interviewed staff reported that the facility conducts criminal background checks on all hired staff. The agency reported that they currently use a company called First Advantage to do all background checks on any new employees. Also, our current policy is we do background checks every 5 years for all employees.

Corrective Action: The 5-year background checks were run during the course of the audit phase.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.217 (f). The agency shall also ask all applicants and employees who may have contact with residents directly about

previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct. Said information is a part of the agency application.

Documentation Reviewed

Applications (9)

Interviews

Administrative (Human Resources) Staff – The interviewed staff reported that in the employment application, we have an authorization form for background checks and offer an opportunity to disclose any and all misconduct. Such questions are asked on the employee application.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.217 (g). As reported in the PAQ, the agency policy states that material omission regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Policy: The Hiring and Promotion Decisions policy states that “Material omissions regarding such misconduct or the provision of materially false information regarding such misconduct may be grounds for termination”.

Interviews

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.217 (h). Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

Documentation Reviewed

If providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law, review a copy of the law.

Policy: The Hiring and Promotion Decisions policy states that “To the extent allowed by Connecticut law The Open Hearth shall provide information on substantiated allegations of sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work”.

Interviews

Administrative (Human Resources) Staff – The interviewed staff reported that the facility has never received a request from a former employee to provide information on substantiated or unsubstantiated allegations of sexual abuse or sexual harassment; however, if requested the facility will provide the information.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

Corrective Action and Conclusion:

Corrective Action: 115.217 (d). During the documentation review phase, it was determined that the agency did not have policy language to address the provision. During the onsite phase, the agency immediately updated its policy to reflect the requirements of the provision. There is no further action needed.

Corrective Action: 115.217 (e). The 5-year background checks were run during the course of the audit phase.

Corrective Action: While the facility did not report any identified contracted staff the auditor notified the facility that the requirement for a background check is related to having contact and/or providing a service not have unsupervised contact; therefore, all contracted staff providing services to residents shall have a background check. It is further recommended that the facility attempt to conduct the reference checks and document that there is not a response from the prior instructional employer. The facility director shall issue a directive or establish a process that all volunteers and contractors providing services to residents are background checked. The facility issued a directive addressing the agency requirement to complete background checks on volunteers and contractors and prior institutional reference checks on employees and a directive for conducting reference checks. No further action is warranted. The facility is in compliance with the standard.

115.218	Upgrades to facilities and technology
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Zero Tolerance Sales Contract (Teleworks Communications, Inc.) Interviews: Agency Head Director Findings (By Provision): 115.218 (a). As reported in the PAQ, the agency/facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later. Interviews Agency Head – The interviewed agency head reported that the agency has not done any “substantial modifications to facilities” in the past twenty years nor does it contemplate any in the foreseeable future. Director or Designee – The interviewed staff reported that with the exception of video monitoring there have been no significant changes to the facility. PREA Audit Site Review: During the tour the auditor did not observe any significant upgrades to the facility. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.218 (b). As reported in the PAQ, the facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit. The facility utilized a contracted agency to provide video monitoring upgrades in 2021. Documentation Reviewed Update of the video monitoring system (Sales Contract/Teleworks Communications, Inc.) Interviews: Agency Head – The interviewed agency head reported that when installing the electronic monitoring (camera) system this past year the safety and privacy of the residents were the chief concerns. Camera placement and monitoring station placement decisions were made for the protection of the residents. Director or Designee – The interviewed staff reported that when decisions were made concerning placement of cameras the safety and privacy of the residents was of primary concern. In addition to camera placement the ability of the camera to record events and access to the recording was a priority. A group of staff and consultants toured the building several times. The group consisted of myself, the Facilities Director, the Associate Counselor (direct service staff) Supervisor, and two outside consultants. These tours were made to determine the best placement of the cameras. Also, of concern was who would have access to monitoring the cameras. Perhaps as important as original placement of the cameras was continuing to monitor their placement to determine if additional cameras were necessary of if adjustments to the current placement were required. PREA Audit Site Review: During the tour, the auditor was able to observe where the video monitoring is located throughout the facility. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

	Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.221	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Evidence Protocol and Forensic Medical Examinations Sexual Assault Crisis Center of Eastern Connecticut MOA YWCA of New Britain Interviews: Random Sample of Staff (12) Findings (By Provision): 115.221 (a). As reported in the PAQ, the agency/facility is not responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The agency/facility is not responsible for conducting criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Connecticut Department of Corrections is responsible for conducting criminal investigations. Interviews Random Sample of Staff – The interviewed staff reported that the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse include remove the person from the area and get them to a safe location, secure the scene, and make sure no one comes in the area or touches anything. When probed, some of the ways it was described that the evidence would not get contaminated includes no showering, brushing teeth or changing clothes. However, one staff member reported that they would place items in a toxic bag. When asked who conducts the interviews the residents reported the director or the agency head. One staff stated that they would start the investigative process. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.221 (b). NA-there are no youth housed at the placement. 115.221 (c). As reported in the PAQ, the facility offers all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are not conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. Policy: The Evidence Protocol and Forensic Medical Examinations policy states that "The Open Hearth shall offer all victims of sexual abuse access to forensic medical examinations at an outside facility, (Hartford Hospital or CTDOC) without financial cost, where evidentiary or medically appropriate". The number of forensic medical exams conducted during the past 12 months: 0 The number of exams performed by SANEs/SAFEs during the past 12 months: 0 The number of exams performed by a qualified medical practitioner during the past 12 months: 0 Documentation Reviewed MOA YWCA of New Britain Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.221 (d). As reported in the PAQ, the facility attempts to make available to the victim a victim advocate from a rape crisis center, either in person or by other mean. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member. Policy: The Evidence Protocol and Forensic Medical Examinations policy states that "TOH shall attempt to make available to

the victim a victim advocate from CONNSACS".

Documentation Reviewed

MOA YWCA of New Britain

Interviews

PREA Coordinator – The interviewed staff reported that TOH has a Memorandum of Agreement with the YWCA of New Britain. The YWCA of New Britain provides free, confidential and empowerment based sexual assault crisis and advocacy services including a 24-hour hotline, individual counseling, medical and legal accompaniment and support. The MOA with the New Britain YWCA states "This agreement is made pursuant to the Department of Justice National Standards to prevent, detect, and respond to prison rape"

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.221 (e). As reported in the PAQ, if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

Policy: The Evidence Protocol and Forensic Medical Examinations policy states that "As requested by the victim, The Victim Advocate shall accompany and support the victim through investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals".

Documentation Reviewed

MOA YWCA of New Britain

Interviews

PREA Coordinator – The interviewed staff stated that TOH has a relationship with Hartford Health Care and Charter Oak Health Center both of whom provide trauma informed treatment. In addition, TOH has a Memorandum of Agreement with the YWCA of New Britain. The YWCA of New Britain provides free, confidential and empowerment based sexual assault crisis and advocacy services including a 24 hour hotline, individual counseling, medical and legal accompaniment and support.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.221 (f). As reported in the PAQ, if the agency is not responsible for investigating allegations of sexual abuse and relies on another agency to conduct these investigations, the agency has requested that the responsible agency follow the requirements of paragraphs §115.221 (a) through (e) of the standards.

Documentation Reviewed

MOA YWCA of New Britain

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.221 (g). Auditor is not required to audit this provision.

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.222	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Referrals of Allegations for Investigations Interviews: Agency Head Investigative Staff Findings (By Provision): 115.222 (a). As reported in the PAQ, the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse or staff sexual misconduct). In the past 12 months, the number of allegations of sexual abuse and sexual harassment that were received: 0. In the past 12 months, the number of allegations resulting in an administrative investigation: 0. In the past 12 months, the number of allegations referred for criminal investigation: 0. Policy: The Referrals of Allegations for Investigations policy states that “The Connecticut State Police shall serve as the primary investigating authority in all incidents of sexual abuse within the program. All such referrals to police shall be documented. The Agency’s PREA Coordinator shall assist the appropriate law enforcement agency as appropriate and shall conduct a separate internal investigation into the incident. The incident shall be reported to CTDOC, and at their discretion, CTDOC shall conduct an investigation. In the event the appropriate law enforcement agency refuses to investigate a sexual abuse allegation, such refusal shall be documented and reported immediately to CTDOC”. Documentation Reviewed Review: Documentation of reports of sexual abuse and sexual harassment and documentation of investigations, including full investigative reports with findings. Interviews Agency Head – The interviewed staff reported that TOH does not conduct administrative or criminal investigations. Administrative investigations are the responsibility of The Connecticut Department of Corrections and criminal investigations are the responsibility of local and/or state police. Allegations of sexual abuse or harassment are immediately reported to the Connecticut Department of Corrections. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.222 (b). As reported in the PAQ, the agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The agency’s policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website or made publicly available via other means. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. Policy: The Referrals of Allegations for Investigations policy states that “The Connecticut State Police shall serve as the primary investigating authority in all incidents of sexual abuse within the program. All such referrals to police shall be documented. The Agency’s PREA Coordinator shall assist the appropriate law enforcement agency as appropriate and shall conduct a separate internal investigation into the incident. The incident shall be reported to CTDOC, and at their discretion, CTDOC shall conduct an investigation. In the event the appropriate law enforcement agency refuses to investigate a sexual abuse allegation, such refusal shall be documented and reported immediately to CTDOC”. Interviews

	Investigative Staff – The outside interviewed investigator reported that the agency policies require that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.222 (c). If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity. Documentation Reviewed Website Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.222 (d). Auditor is not required to audit this provision. 115.222 (e). Auditor is not required to audit this provision. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.231	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Employee Training New Employee Training Memo Training Records · 8 New Hire · 27 Refresher Material: · Training Policy/First Responder Protocol · Video: What You Need to Know · Video: PREA Employee Training Unit 3 Interviews: Random Sample of Staff (12) Findings (By Provision): 115.231 (a). As reported in the PAW, the agency trains all employees who may have contact with residents on the agency's zero-tolerance policy for sexual abuse and sexual harassment. The agency trains all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. The agency trains all employees who may have contact with residents on the right of residents to be free from sexual abuse and sexual harassment. The agency trains all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment. The agency trains all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in confinement. The agency trains all employees who may have contact with residents on the common reactions of sexual abuse and sexual harassment victims. The agency trains all employees who may have contact with residents on how to avoid inappropriate relationships with residents. The agency trains all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents. The agency trains all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Policy: The Employee Training policy states that: During employee orientation and annually thereafter, staff shall receive the following PREA training: a. The facility's zero tolerance for all forms of sexual abuse and sexual harassment; b. How to fulfill their responsibilities in regards to prevention, detection, reporting, and response; c. The resident's right to be free from of sexual abuse and sexual harassment; d. The resident's and staff member's right to be free from retaliation for reporting sexual abuse and sexual harassment e. The dynamics of sexual abuse and sexual harassment in residential settings, including determining which residents are most vulnerable, f. The common reactions of sexual assault or sexual abuse victims;

g. How to avoid inappropriate relationships with residents;

h. How to communicate effectively and professionally with all residents, and

i. How to comply with relevant laws related to the mandatory reporting of sexual abuse to authorities.

During the onsite phase the auditor reviewed the PREA Training Curriculum, and it was determined that the curriculum covers all of the required elements of staff PREA training. The auditor reviewed a sample of 35 training records (PREA Acknowledgement Statements). The training records reviewed included initial and refresher training covering a time span of 2022-2019.

Documentation Reviewed

PREA Acknowledgement Statements (35)

Interviews

Random Sample of Staff – All but one of the interviewed staff reported that they have been trained on the agencies zero tolerance policy for sexual abuse and sexual harassment. The staff reported that the training included:

· The agency's zero-tolerance policy on sexual abuse and sexual harassment?

· How to fulfill your responsibilities regarding sexual abuse and sexual harassment prevention, detection, reporting, and response, in accordance with agency policies and procedures?

· Resident's right to be free from sexual abuse and sexual harassment?

· Residents' and employees' right to free from retaliation for reporting sexual abuse and sexual harassments?

· The dynamics of sexual abuse and sexual harassment in confinement?

· The common reactions of sexual abuse and sexual harassment victims?

· How to detect and respond to signs of threatened and actual sexual abuse?

· How to avoid inappropriate relationship with residents?

· How to communicate effectively and professionally with residents, including lesbians, gay, bisexual, transgender, intersex, or gender nonconforming residents?

· How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?

· Relevant laws regarding the applicable age of consent?

The staff consistently reported that they were trained on initial hire and that they receive monthly training during staff meeting. When probed the staff were able to describe things like the common reactions of victims, what to look for, and how to respectfully talk to residents who may be lesbian, gay, bisexual, transgender or gender non-conforming. One staff reported that they could not recall receiving any training.

Corrective Action: Upon file review it was determined that several staff did not receive their training upon hire. The facility director issued a corrective action memo stating that "to make certain that all newly hired staff are trained in PREA in a timely manner a check sheet will be developed that includes all pre-employment requirements. That list will include PREA training. The training will be conducted by Kevin Johns and his sign off, indicated that the successful completion of PREA training, will be required before any individual can start an assignment at TOH that requires contact with DOC residents.

115.231 (b). As reported in the PAQ, the training is tailored to the gender of the residents at the facility.

Documentation Reviewed

Employee PREA Training Acknowledgment (35)

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.231 (c). As reported in the PAQ, in between trainings the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and harassment. The frequency with which employees who may have contact with residents receive refresher training on PREA requirements is annually.

During the onsite phase the auditor reviewed the PREA Training Curriculum, and it was determined that the curriculum

covers all of the required elements of staff PREA training. The auditor reviewed a sample of 35 training records (PREA Acknowledgement Statements). The training records reviewed included initial and refresher training covering a time span of 2022-2019.

Documentation Reviewed:

Employee PREA Training Acknowledgment (35)

Interviews

Corrective Action: Upon file review it was determined that several staff did not receive their training upon hire. The facility director issued a corrective action memo stating that “to make certain that all newly hired staff are trained in PREA in a timely manner a check sheet will be developed that includes all pre-employment requirements. That list will include PREA training. The training will be conducted by Kevin Johns and his sign off, indicated that the successful completion of PREA training, will be required before any individual can start an assignment at TOH that requires contact with DOC residents.

115.231 (d). The agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

The auditor reviewed a sample of 35 training records (Signed PREA Acknowledgement Statements). The training records reviewed included initial and refresher training covering a time span of 2022-2019.

Documentation Reviewed

PREA Training Acknowledgement (35)

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action: Upon file review it was determined that several staff did not receive their training upon hire. The facility director issued a corrective action memo stating that “to make certain that all newly hired staff are trained in PREA in a timely manner a check sheet will be developed that includes all pre-employment requirements. That list will include PREA training. The training will be conducted by Kevin Johns and his sign off, indicated that the successful completion of PREA training, will be required before any individual can start an assignment at TOH that requires contact with DOC residents.

Corrective Action and Conclusion:

Corrective Action: Upon file review it was determined that several staff did not receive their training upon hire. The facility director issued a corrective action memo stating that “to make certain that all newly hired staff are trained in PREA in a timely manner a check sheet will be developed that includes all pre-employment requirements. That list will include PREA training. The training will be conducted by Kevin Johns and his sign off, indicated that the successful completion of PREA training, will be required before any individual can start an assignment at TOH that requires contact with DOC residents.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No further action is warranted.

115.232	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Volunteer and Contractor Training PREA Visitor Acknowledgement Interviews: · Volunteer(s) or Contractor(s) who may have Contact with Residents Findings (By Provision): 115.232 (a). As reported in the PAQ, all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The number of volunteers and individual contractors who have contact with residents who have been trained in agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 0. Policy: The Volunteer and Contractor Training policy states that "All volunteers or contractors who will be working unaccompanied by staff with residents will receive the same training as noted above for employees". Documentation Reviewed: Contractor Signed PREA Acknowledgement Statement (blank) Recommendation: While the facility did not report there was volunteers or contractors who provided services, the auditor noticed during the site inspection that there was a community-based provider, providing medical services. The medical staff had not signed or received any information related to PREA. The facility director reported that the attempted to have them sign the acknowledgement statement, however they did not therefore the onsite services was terminated until the documentation is signed. The auditor recommended to the facility that anyone providing services to residents, whether the services are supervised or unsupervised shall receive the agencies zero tolerance policy on sexual abuse and sexual harassment of residents along with signing an acknowledgement statement. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.232 (b). As reported in the PAQ, the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. Policy: The Volunteer and Contractor Training policy states that "All volunteers and contractors who will be working unaccompanied by staff with shall sign an acknowledgment that they have received PREA training and that they understand the PREA policy". Documentation Reviewed Contractor Signed PREA Acknowledgement Statement (blank) Recommendation: While the facility did not report there was volunteers or contractors who provided services, the auditor noticed during the site inspection that there was a community-based provider, providing medical services. The medical staff had not signed or received any information related to PREA. The facility director reported that the attempted to have them sign the acknowledgement statement, however they did not therefore the onsite services was terminated until the documentation is signed. The auditor recommended to the facility that anyone providing services to residents, whether the services are supervised or unsupervised shall receive the agencies zero tolerance policy on sexual abuse and sexual harassment of residents along with signing an acknowledgement statement. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the

	facility is in compliance with the provisions of this standard.: 115.232 (c). As reported in the PAQ, the agency maintains documentation confirming that volunteers and contractors who have contact with residents understand the training they have received. Documentation Reviewed Contractor Signed PREA Acknowledgement Statement (blank) Recommendation: While the facility did not report there was volunteers or contractors who provided services, the auditor noticed during the site inspection that there was a community-based provider, providing medical services. The medical staff had not signed or received any information related to PREA. The facility director reported that the attempted to have them sign the acknowledgement statement, however they did not therefore the onsite services was terminated until the documentation is signed. The auditor recommended to the facility that anyone providing services to residents, whether the services are supervised or unsupervised shall receive the agencies zero tolerance policy on sexual abuse and sexual harassment of residents along with signing an acknowledgement statement. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Corrective Action and Conclusion: Recommendation: While the facility did not report there was volunteers or contractors who provided services, the auditor noticed during the site inspection that there was a community-based provider, providing medical services. The medical staff had not signed or received any information related to PREA. The facility director reported that the attempted to have them sign the acknowledgement statement, however they did not therefore the onsite services was terminated until the documentation is signed. The auditor recommended to the facility that anyone providing services to residents, whether the services are supervised or unsupervised shall receive the agencies zero tolerance policy on sexual abuse and sexual harassment of residents along with signing an acknowledgement statement.

115.233	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Resident Education Intake Records of Residents (47) Resident Education Curriculum Memo: Resident PREA Orientation Revised PREA Acknowledgement Form Updated Resident PREA Acknowledgement Form Interviews Intake Staff Resident Interview Questionnaire (10) Findings (By Provision): 115.233 (a). Residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The number of residents admitted during past 12 months who were given this information at intake: 88. Policy: The Resident Education policy states that “During the intake process, residents shall receive information explaining The Open Hearths zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents”. All intakes watch the video, PREA: What You Need to Know, produced by Justice International https://www.youtube.com/watch?v=ag-__vbx5Mg The viewing is followed up with a conversation with the Intake Coordinator to insure the resident’s understanding. Documentation Reviewed: Intake Records of Residents (47) Education Material Memo: Resident PREA Orientation Updated Resident PREA Acknowledgement Form Interviews: Intake Staff – The interviewed intake staff reported that they provide residents with information about the zero--tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. They will ask them if they understand the information, what is being told to them and if there is anything that they don’t understand. Additionally, staff reported that they will have them sign a PREA acknowledgement form. Resident Interview Questionnaire – All of the interviewed residents reported receiving information upon arrival on the rules against sexual abuse and sexual harassment. When probed the residents stated that the staff went over paperwork with them, however many could not recall watching a video. Several residents further stated that the staff handed them the

paperwork and they signed something however they could not recall three could not recall if they were informed of their right to not be sexually abused or sexually harassed, how to report sexual abuse or sexual harassment, and their right to not be punished for reporting sexual abuse or sexual harassment.

Corrective Action: During the onsite review, the residents indicated that they did not watch the PREA video. It was further determined that the residents were expected to watch the video on their own. The facility director wrote a memo indicating that “effective immediately new residents should not be given the web site for the PREA orientation and asked to watch it at their convenience. New residents should view the video during the intake process. Further, follow-up questions should be asked to ensure that the resident understands what is viewed and be given the opportunity to ask questions and/or express concerns”. The director provided additional guidance to the intake staff and updated the acknowledgement form to address the above-mentioned concern. The auditor reviewed new resident education forms showing practice was implemented.

The PREA Acknowledgement for was revised to state:

PREA ACKNOWLEDGEMENT

I have read, or it has been read to me, The Open Hearth’s Prison Rape Elimination Act policies including the zero tolerance stance and the different methods by which I can report sexual harassment or abuse. In addition, during the intake process, with Open Hearth staff, I viewed the video PREA: What You Need To Know. After watching the video, I was given the opportunity to ask questions for understanding and clarification. I agree to abide by and follow the rules and regulations regarding PREA during my stay at the Open Hearth.

115.233 (b). As reported in the PAQ, the facility provides residents who are transferred from a different community confinement facility with refresher information referenced in 115.233(a)-1. The number of residents transferred from a different community confinement facility during the past 12 months: 7. The number of residents transferred from a different community confinement facility, during the past 12 months, who received refresher information: 7.

Policy: The Resident Education policy states that “The Open Hearth shall provide refresher information whenever a resident is transferred to a different facility”

Documentation Reviewed

Intake Records of Residents (47)

Intake records of residents entering the facility in the last 12 months (spot check). Log or other record corroborating that residents received information at intake (e.g., resident signatures). Any relevant education materials (e.g., resident handbook) to ensure that relevant information is covered.

Interviews

Intake Staff – The interviewed staff reported that they ensure that residents are educated regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents by asking them if they understand the information being presented and explain anything that they don’t understand. Along with having them sig the PREA acknowledgement statement. This is usually done on the same day and could be up to 72 hours if they come late on a Friday evening. I have a verbal conversation as they come in on Friday and go over the in-depth process on Monday.

Resident Interview Questionnaire – The interviewed residents reported that they arrived at the facility within the last 12 months. All but one of the interviewed residents transferred from another facility.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.233 (c). As reported in the PAQ, resident PREA education is available in formats accessible to all residents, including those who are limited English proficient. Resident PREA education is available in formats accessible to all residents, including those who are deaf. Resident PREA education is available in formats accessible to all residents, including those who are visually impaired. Resident PREA education is available in formats accessible to all residents, including those who are otherwise disabled. Resident PREA education is available in formats accessible to all residents, including those who are limited in their reading skills.

Policy: The Resident Education policy states that “The Open Hearth shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, otherwise disabled as well as to residents who have limited reading skills. The Open Hearth shall maintain documentation of resident participation in these education sessions. In addition to providing such education, The Open Hearth shall ensure that key information is continuously and readily available or visible to residents through posters and brochures”.

All intakes watch the video, PREA: What You Need to Know, produced by Justice International

https://www.youtube.com/watch?v=ag-__vbx5Mg

The viewing is followed up with a conversation with the Intake Coordinator to insure the resident's understanding

Reviewed

Education Material

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.233 (d). As reported in the PAQ, the agency maintains documentation of resident participation in PREA education sessions.

Documentation Reviewed

PREA Acknowledgement Statements (47)

Memo: Resident PREA Orientation

Updated Resident PREA Acknowledgement Form

Interviews

Corrective Action: During the onsite review, the residents indicated that they did not watch the PREA video. It was further determined that the residents were expected to watch the video on their own. The facility director wrote a memo indicating that "effective immediately new residents should not be given the web site for the PREA orientation and asked to watch it at their convenience. New residents should view the video during the intake process. Further, follow-up questions should be asked to ensure that the resident understands what is viewed and be given the opportunity to ask questions and/or express concerns". The director provided additional guidance to the intake staff and updated the acknowledgement form to address the above-mentioned concern. The auditor reviewed new resident education forms showing practice was implemented.

The PREA Acknowledgement for was revised to state:

PREA ACKNOWLEDGEMENT

I have read, or it has been read to me, The Open Hearth's Prison Rape Elimination Act policies including the zero-tolerance stance and the different methods by which I can report sexual harassment or abuse. In addition, during the intake process, with Open Hearth staff, I viewed the video PREA: What You Need to Know. After watching the video, I was given the opportunity to ask questions for understanding and clarification. I agree to abide by and follow the rules and regulations regarding PREA during my stay at the Open Hearth.

115.233 (e). As reported in the PAQ, the agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

Policy: The Resident Education policy states that "In addition to providing such education, The Open Hearth shall ensure that key information is continuously and readily available or visible to residents through posters and brochures".

Documentation Reviewed

Education Material

PREA Audit Site Review: During the onsite inspection the auditor observed PREA posters, resident handbooks, PREA brochures and information regarding the advocacy services throughout the common areas of all sites.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion:

Corrective Action: During the onsite review, the residents indicated that they did not watch the PREA video. It was further determined that the residents were expected to watch the video on their own. The facility director wrote a memo indicating that "effective immediately new residents should not be given the web site for the PREA orientation and asked to watch it at their convenience. New residents should view the video during the intake process. Further, follow-up questions should be asked to ensure that the resident understands what is viewed and be given the opportunity to ask questions and/or express concerns". The director provided additional guidance to the intake staff and updated the acknowledgement form to address the above-mentioned concern. The auditor reviewed new resident education forms showing practice was implemented.

	A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No further action is warranted.

115.234	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Zero Tolerance Specialized Training Certificate Interviews: Investigative Staff (outside investigator) Findings (By Provision): 115.234 (a). N/A-As reported in the PAQ, the agency does not conduct any sexual abuse or sexual harassment allegations investigations. However, there is one staff onsite who has completed the specialized training for investigators “Sexual Abuse in a Confinement Setting”. Reviewed Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) Interviews Investigative Staff – The outside interviewed investigator reported that they have received training specific to conducting sexual abuse investigations. The training is online through the PREA Resource Center "Your Role in Responding to Sexual Abuse” and “Investigating Sexual Abuse in a Confinement Setting”. The training topics included: · Techniques for interviewing sexual abuse victims · Proper use of Miranda and Garrity warnings · Sexual abuse evidence collection in confinement settings · The criteria and evidence required to substantiate a case for administrative or prosecution referral Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.234 (b). As reported in the PAQ, the agency does not conduct any sexual abuse or sexual harassment allegations investigations. However, there is one staff onsite who has completed the specialized training for investigators “Sexual Abuse in a Confinement Setting”. Documentation Reviewed: Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) Interviews: Investigative Staff – The outside interviewed investigator reported that they have received training specific to conducting sexual abuse investigations. The training is online through the PREA Resource Center "Your Role in Responding to Sexual Abuse” and “Investigating Sexual Abuse in a Confinement Setting”. The training topics included: · Techniques for interviewing sexual abuse victims · Proper use of Miranda and Garrity warnings · Sexual abuse evidence collection in confinement settings · The criteria and evidence required to substantiate a case for administrative or prosecution referral Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the

	facility is in compliance with the provisions of this standard. 115.234 (c). As reported in the PAQ, the agency does not conduct any sexual abuse or sexual harassment allegations investigations. The number of investigators currently employed who have completed the required training: 0. However, there is one staff onsite who has completed the specialized training for investigators “Sexual Abuse in a Confinement Setting”. Documentation Reviewed: Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.234 (d). Auditor is not required to audit this provision. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.235	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Findings (By Provision): 115.235 (a). N/A-As reported in the PAQ, the agency does not have onsite medical or mental health staff. The number of all medical and mental health care practitioners who work regularly at this facility and have received the training required by agency policy: 0. The percent of all medical and mental health care practitioners who work regularly at this facility and have received the training required by agency policy: 0 Recommendation: While the facility did not report there was volunteers or contractors who provided services, the auditor noticed during the site inspection that there was a community-based provider, providing medical services. The medical staff had not signed or received any information related to PREA. The facility director reported that the attempted to have them sign the acknowledgement statement, however they did not therefore the onsite services was terminated until the documentation is signed. The auditor recommended to the facility that anyone providing services to residents, whether the services are supervised or unsupervised shall receive the agencies zero tolerance policy on sexual abuse and sexual harassment of residents along with signing an acknowledgement statement. 115.235 (b). NA- the agency does not have onsite medical and mental health services. 115.235 (c). NA- the agency does not have onsite medical and mental health services. 115.235 (d). NA- the agency does not have onsite medical and mental health services. Corrective Action and Conclusion: Recommendation: While the facility did not report there was volunteers or contractors who provided services, the auditor noticed during the site inspection that there was a community-based provider, providing medical services. The medical staff had not signed or received any information related to PREA. The facility director reported that the attempted to have them sign the acknowledgement statement, however they did not therefore the onsite services was terminated until the documentation is signed. The auditor recommended to the facility that anyone providing services to residents, whether the services are supervised or unsupervised shall receive the agencies zero tolerance policy on sexual abuse and sexual harassment of residents along with signing an acknowledgement statement.

115.241	Screening for risk of victimization and abusiveness
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Screening for Risk of Sexual Victimization and Abusiveness Screening Tool/Risk Assessment Resident Risk Assessments (46) Resident Risk Re-Assessments (14) Interviews: Staff Responsible for Risk Screening Resident Interview Questions (10) PREA Coordinator Findings (By Provision): 115.241 (a). As reported in the PAQ, the agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. Policy: The Screening for Risk of Sexual Victimization and Abusiveness policy states that “The Open Hearth does not accept residents who have histories of sexual aggression or abuse or who are considered to be at risk of being sexually aggressive or abusive. The Intake Coordinator shall monitor intake materials to ensure that this policy is followed. All clients shall be assessed during an intake screening for the risk of being sexually abused by other clients” Interviews Staff Responsible for Risk Screening – The interviewed staff reported that they screen residents upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. Resident Interview Questionnaire – Seven of the interviewed residents reported that on the first day at the facility they were asked questions like whether or not they had been in jail or prison before, whether they have been sexually abused, whether they identify as gay, lesbian, bisexual, or whether they may be in danger of sexual abuse. When probed three of the residents further stated that they think they were asked such questions but couldn’t recall which questions were asked. PREA Audit Site Review: There were no residents admitted during the onsite inspection therefore the auditor did not observe any new intakes. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.241 (b). According to the PAQ, the policy requires that residents be screened for risk of sexual victimization or risk of sexual abusing other residents within 72 hours of their intake. The number of residents entering the facility (either through intake or transfer) within the past 12 months (whose length of stay in the facility was for 72 hours or more) who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 88. Policy: The Screening for Risk of Sexual Victimization and Abusiveness policy states that “Intake Screening shall take place within 72 hours of arrival to TOH”. Documentation Reviewed Records for residents admitted to the facility within the past 12 months for evidence of appropriate screening within 72 hours (46) Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that residents are typically screened on the first day for risk of sexual victimization or risk of sexually abusing others, unless the resident comes in late on a Friday.

Resident Interview Questionnaire – Seven of the interviewed residents reported that on the first day at the facility they were asked questions like whether or not they had been in jail or prison before, whether they have been sexually abused, whether they identify as gay, lesbian, bisexual, or whether they may be in danger of sexual abuse. When probed three of the residents further stated that they think they were asked such questions but couldn't recall which questions were asked.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.241 (c). As reported in the PAQ, the facility uses a risk assessment is conducted using an objective screening instrument.

Documentation Reviewed

Records for residents admitted to the facility within the past 12 months for evidence of appropriate screening within 72 hours (46)

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.241 (d). The intake screening shall consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (1) Whether the resident has a mental, physical, or developmental disability; (2) The age of the resident; (3) The physical build of the resident; (4) Whether the resident has previously been incarcerated; (5) Whether the resident's criminal history is exclusively nonviolent; (6) Whether the resident has prior convictions for sex offenses against an adult or child; (7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the resident has previously experienced sexual victimization; and (9) The resident's own perception of vulnerability.

Policy: The Screening for Risk of Sexual Victimization and Abusiveness policy states that "The screening tool used shall be TOH PREA Intake Risk Assessment".

Documentation Reviewed

Records for residents admitted to the facility within the past 12 months for evidence of appropriate screening within 72 hours (46)

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the initial risk screening looks for age, height, if they have been sexual abuse or abused someone, and assault charges. When conducting the initial screening, the client is in front of them and they will go over the forms with them. Then we will have them watch the video and go over the PREA pamphlet. Follow up questions will proceed.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.241 (e). The intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive.

As previously stated, the policy indicates that "The Open Hearth does not accept residents who have histories of sexual aggression or abuse or who are considered to be at risk of being sexually aggressive or abusive. The Intake Coordinator shall monitor intake materials to ensure that this policy is followed".

Documentation Reviewed

Records for residents admitted to the facility within the past 12 months for evidence of appropriate screening within 72 hours (46)

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the initial risk screening looks for age, height, if they have been sexual abuse or abused someone, and assault charges. When conducting the initial screening, the client is in front of them, and they will go over the forms with them. Then we will have them watch the video and go over the PREA pamphlet. Follow up questions will proceed.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.241 (f). As reported in the PAQ, the policy requires that the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The number of residents entering the facility (either through intake or transfer) within the past 12 months whose length of stay in the facility was for 30 days or more who were reassessed for their risk of sexual victimization or of being sexually abusive within 30 days after their arrival at the facility based upon any additional, relevant information received since intake: 0.

Policy: The Screening for Risk of Sexual Victimization and Abusiveness policy states that "Within 30 days from the client's arrival at TOH, the client will be reassessed to see if the client is at risk for victimization or abusiveness based upon any additional, relevant information received by TOH staff since the intake screening".

Documentation Reviewed

Records for residents admitted to the facility within the past 12 months for evidence of appropriate screening within 72 hours (46)

Rescreening (14)

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that they have not had a reason to reassess as there has not been an allegation of sexual abuse.

Resident Interview Questionnaire – All of the interviewed residents reported that they could not recall whether or not the staff have asked them the screening intake questions again since they have been here. It should also be noted that half of the interviewed residents had not been at the facility for 30 days for the reassessment.

Corrective Action: Upon file review and interviews, it was determined that the facility was not conducting the reassessment of residents, unless there was a PREA allegation. The agency policy along with the corrective action put in place during the last audit indicated that the facility would conduct the initial reassessment at 30 days from the arrival at the facility. A corrective action was put into place during the site inspection. The facility provided the auditor with reassessments that were conducted. The facility shall provide the auditor with the additional reassessments that were conducted to ensure the practice of reassessments is in place. Three additional rescreening's were provided on residents who arrived at the facility within the last 60 days. No further action is needed.

115.241 (g). As reported in the PAQ, the policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

Policy: The Screening for Risk of Sexual Victimization and Abusiveness policy states that "A client's risk level shall be reassessed when warranted due to referral request, incident of sexual abuse, or receipt of additional information that bears on the client's risk of sexual victimization or abusiveness".

Documentation Reviewed

Rescreening (30 Day Follow Up Review)

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that they have not had a reason to reassess as there has not been an allegation of sexual abuse.

Resident Interview Questionnaire – All of the interviewed residents reported that they could not recall whether or not the staff have asked them the screening intake questions again since they have been here. It should also be noted that half of the interviewed residents had not been at the facility for 30 days for the reassessment.

Discussion: The facility reported that there was no information provided that would warrant a reassessment based on a referral, request, incident of sexual abuse or receipt of additional information. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.241 (h). As reported in the PAQ, the policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) the questions regarding: (a) whether or not the resident has a mental, physical, or developmental disability; (b) whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex,

or gender non-conforming; (c) Whether or not the resident has previously experienced sexual victimization; and (d) the resident's own perception of vulnerability.

Policy: The Screening for Risk of Sexual Victimization and Abusiveness policy states that "Client's will not be disciplined for refusing to answer, or for not disclosing complete information in response to the screening process".

Documentation Reviewed

Records for residents admitted to the facility within the past 12 months for evidence of appropriate screening within 72 hours (46)

Rescreening (11)

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that residents are not disciplined for refusing to respond to any parts of the PREA assessment.

115.241 (i). The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Policy: The Screening for Risk of Sexual Victimization and Abusiveness policy states that "TOH will ensure all information acquired in the screening process will be confidential".

Interviews

PREA Coordinator - The interviewed staff stated that the agency has outlined who should have access to a residents risk assessment within the facility in order to protect sensitive information from exploitation. Access to the information on the screening tool is on a need-to-know basis. The Intake Coordinator shares the information with other staff only to the extent that it facilitates the appropriate treatment of the resident. The information is confidential. Except for CTDOC the information would only be shared with outside entities with the residents expressed (written) permission.

Staff Responsible for Risk Screening – The interviewed staff reported that the case managers are the only ones who have access to the resident's risk assessment within the facility, along with the PO and the Program Director.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

Corrective Action and Conclusion:

Corrective Action: 114.217 (f). Upon file review and interviews, it was determined that the facility was not conducting the reassessment of residents, unless there was a PREA allegation. The agency policy along with the corrective action put in place during the last audit indicated that the facility would conduct the initial reassessment at 30 days from the arrival at the facility. A corrective action was put into place during the site inspection. The facility provided the auditor with reassessments that were conducted. The facility shall provide the auditor with the additional reassessments that were conducted to ensure the practice of reassessments is in place. Three additional rescreening's were provided on residents who arrived at the facility within the last 60 days. No further action is needed. The facility is in compliance with the standard.

115.242	Use of screening information
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Use of Screening Information Screening Tool/Risk Assessment Resident Risk Assessments (46) Resident Risk Re-Assessments (11) Memo: Use of Screening Tool Interviews: PREA Coordinator Staff Responsible for Risk Screening Findings (By Provision): 115.242 (a). The agency/facility uses information from the risk screening required by §115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. At the request of the auditor, the facility provided a memo describing the process used to make decisions because of the risk-based screening instrument. It was further reported that the policy was implemented "by reviewing the screening tool and by conversations with the resident. With the safety of the resident in mind the Intake Coordinator will consult with the PREA Coordinator regarding any resident requiring special consideration to determine the proper placement of the resident regarding housing/bed assignments as well as other programmatic placements (e.g., chore assignment). If through consultation with key staff, it is determined that TOH cannot meet the safety and health needs of the resident, the Supervising PO will be immediately notified". Documentation Reviewed Memo: Use of Screening Tool Screening Tool/Risk Assessment Resident Risk Assessments (46) Resident Risk Re-Assessments (11) Interviews PREA Coordinator – The interviewed staff stated that information gleaned from the risk assessment is first utilized to determine a resident's appropriateness for our program. If a resident is deemed to be inappropriate (e.g., risk of sexual aggression) CTDOC will be immediately contacted to secure the transfer of the resident to another facility. If, based on the screening, the resident is appropriate but in need of special consideration the appropriate measures will be put in place. These measures could include, but are not limited to bed/room assignment, chore responsibilities, use of sanitary/showering facilities. Staff Responsible for Risk Screening – The interviewed staff reported that if they have any concerns or areas that need to be addressed, we will take into consideration where to place them. If they need special or own shower time. Will assess whether they feel comfortable in a dorm or in a certain housing area. David makes room assignments. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.242 (b). As reported in the PAQ, the agency/facility makes individualized determinations about how to ensure the safety

of each resident.

Policy: The Use of Screening Information policy states that “TOH will individualize determinations about how to ensure the safety of each client”.

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that if they have any concerns or areas that need to be addressed, we will take into consideration where to place them. If they need special or own shower time. Will assess whether they feel comfortable in a dorm or in a certain housing area. David makes room assignments.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.242 (c). As reported in the PAQ, the agency/facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

The facility did not have the required language for this standard. The facility immediately rectified and updated the policy.

Corrective Action (Policy Update)

Policy: The Use of Screening Information policy states that “TOH makes housing/bed and programming assignments for transgender or intersex residents on an individual’s case-by-case basis”.

Interviews

PREA Coordinator – The interviewed staff stated that If a resident is determined to be in need of special consideration based on gender identity the appropriate measures will be put in place. These measures could include, but are not limited to bed/room assignment, chore responsibilities, use of sanitary facilities. Information gleaned from referral materials and the risk assessment is utilized to determine a resident’s appropriateness for our program. In the event that a resident is deemed to be inappropriate (e.g. risk of sexual aggression) CTDOC will be immediately contacted to secure transfer of the resident. If, based on the screening, the resident is appropriate but in need of special consideration the appropriate measures will be put in place. These measures could include, but are not limited to bed/room assignment, chore responsibilities, use of sanitary facilities. Information gleaned from the risk assessment (and other sources) is utilized to determine a resident’s appropriateness for our program. If a resident is deemed to be inappropriate (e.g., risk of sexual aggression) CTDOC will be immediately contacted to secure transfer of the resident. While awaiting a response from CTDOC the resident will be kept under the appropriate supervision.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.242 (d). A transgender or intersex resident's own view with respect to his or her own safety shall be given serious consideration.

Policy: The Use of Screening Information policy states that “Transgender or intersex client’s own view with respect to his or her own safety shall be given serious consideration”.

Interviews

PREA Coordinator – The interviewed staff stated that transgender or intersex individuals’ self-identification is the primary (not the only) basis upon which decisions are made.

Staff Responsible for Risk Screening – The interviewed staff reported that transgender or intersex resident’s own views of his or her own safety is given serious consideration in placement and programming assignments.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.242 (e). Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Policy: The Use of Screening Information policy states that “Transgender and intersex clients will be given the opportunity to shower separately from other clients”.

Documentation Reviewed

Interviews

PREA Coordinator – The interviewed staff stated that transgender or intersex residents are afforded the opportunity to utilize

	a private shower on a floor other than the residence. Staff Responsible for Risk Screening – The interviewed staff reported that all residents are able to shower separately as the site has private bathrooms. PREA Audit Site Review: When conducting the site inspection, the auditor did not observe any living units that appeared designated for transgender or intersex residents. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.242 (f). The agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents. Interviews PREA Coordinator - The interviewed PREA Coordinator reported that the agency is not subject to a consent decree, legal settlement, or legal judgement. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Corrective Action and Conclusion: 115.242 (c). The facility did not have the required language for this standard. The facility immediately rectified and updated the policy. There is no further action needed.

115.251	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Resident Reporting PREA Brochure (English/Spanish) Interviews: Random Sample of Staff (12) Resident Interview Questionnaire (10) Findings (By Provision): 115.251 (a). As reported in the PAQ, the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: (a) sexual abuse or sexual harassment; (b) retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and (c) staff neglect or violation of responsibilities that may have contributed to such incidents. Policy: The Resident Reporting policy states that "TOH will have multiple ways for clients to privately report sexual abuse and sexual harassment, retaliation by other clients or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The methods of reporting include: 1. Reporting to staff that shall be receptive to receive complaints and will forward them to the PREA Coordinator. 2. Reporting complaints directly to the PREA Coordinator. 3. Reporting complaints directly to CTDOC through the PO assigned to TOH program. 4. Reporting directly to law enforcement authorities when complaint is of a criminal nature" Documentation Reviewed PREA Brochure (English/Spanish) Interviews Random Sample of Staff – The interviewed staff reported that residents can privately report sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, or staff neglect or violations of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment. The various methods for which they can report include telling any staff member, the Program Director, and write a grievance. Additionally, it was reported that they can contact the hotline number posted around the facility. Resident Interview Questionnaire – Nine of the interviewed residents reported that they are aware of multiple methods to report sexual abuse or sexual harassment. The various ways reported include tell staff or family, notify police, notify the parole officer, complete a grievance or call the hotline. One resident reported that the only information he was provided was at the prison. PREA Audit Site Review: The auditor observed some posters in the common areas with an outside number to report allegations of sexual abuse and sexual harassment. Corrective Action: The resident handbook was missing some key information to inform residents of their rights on the agencies zero tolerance policy for sexual abuse and sexual harassment. During the post onsite audit phase, the handbook was updated. There is no further action needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.251 (b). As reported in the PAQ, the agency provides at least one way for residents to report abuse or harassment to a

public or private entity or office that is not part of the agency.

Policy: The Resident Reporting policy states that “TOH will have multiple ways for clients to privately report sexual abuse and sexual harassment, retaliation by other clients or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The methods of reporting include:

1. Reporting to staff that shall be receptive to receive complaints and will forward them to the PREA Coordinator.

2. Reporting complaints directly to the PREA Coordinator.

3. Reporting complaints directly to CTDOC through the PO assigned to TOH program.

4. Reporting directly to law enforcement authorities when complaint is of a criminal nature”

Documentation Reviewed

PREA Brochure (English/Spanish)

PREA Coordinator – The interviewed staff reported that the agency provides at least one way for the residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The residents are informed via brochures, posters, and at intake about their options for reporting harassment and/or abuse. The options include:

1. Reporting to staff that shall be receptive to receive complaints and will forward them to the PREA Coordinator.
2. Reporting complaints directly to the PREA Coordinator.
3. Reporting complaints directly to CTDOC through the PO assigned to TOH program.
4. Reporting directly to law enforcement authorities when complaint is of a criminal nature

All reporting entities are aware of their obligation to maintain the confidentiality of the reporter.

Resident Interview Questionnaire – Nine of the interviewed residents reported that they are aware of multiple methods to report sexual abuse or sexual harassment. The various ways reported include tell staff or family, notify police, notify the parole officer, complete a grievance or call the hotline. One resident reported that the only information he was provided was at the prison. When the residents were asked whether or not they are allowed to make a report without having to give their name, two of the residents reported that they were not provided the information to make such a report.

PREA Audit Site Review: The auditor observed PREA related brochures and handouts on the client board. Additionally, there was a locked grievance box in the common area.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.251 (c). As reported in the PAQ, the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports.

Policy: The Resident Reporting policy states that “Reporting can be made verbally, in writing, anonymously, and from third parties. Staff shall promptly document any verbal reports. Receipt of these reports will be delivered to the program manager or PREA coordinator.

TOH staff will have access to file complaints verbally, in writing or anonymously to the PREA Coordinator about any victimization they may have witnessed”.

The Resident Handbook further states that:

TOH has a zero tolerance for any acts of sexual abuse, assault, misconduct or harassment. Sexual activity between staff, volunteers or contracted personnel and residents, as well as between resident and resident is prohibited and subject to administrative and criminal disciplinary sanctions. TOH staff shall take prudent measures to ensure the safety of both residents and staff. All employees, contractors, volunteers and residents shall have a clear understanding that a sexual relationship with an individual under the CTDOC supervision is strictly prohibited and is a serious breach of employee conduct.

Your options for reporting sexual harassment:

1. You can talk to any staff member you feel comfortable with. This can be staff such as a CM, Associate Counselors, Intake Coordinator, or TOH PREA Coordinator.

2. Talk to a professional staff member outside of TOH such as your Parole Officer, Probation Officer, lawyer or public defender, DCF worker/liaison or judge.

3. You can report it privately & anonymously.

4. Contact the statewide Connecticut Sexual Assault Crisis Service (24 hours)

1-888-999-5545 English

1-8880568-8332 Español

PREA COORDINATOR CONTACT INFORMATION

AT THE OPEN HEARTH

Fred Faulkner

Director of Operations

PREA Coordinator

Phone: 860-257-5571

Email: Faulkner@theopenhearth.org

Documentation Reviewed

Resident Handbook

Random Sample of Staff: The interviewed staff reported that when a resident alleges sexual harassment, can he/she do so verbally, in writing, anonymously and through third parties. Such reports can be made immediately. It was reported that documentation can be done by completing an incident report.

Resident Interview Questionnaire – All of the interviewed residents reported that they could make a report either in person or in writing. They further stated that family and friends could make a report for them if needed. It should be further noted that two residents reported not having any family or friends as a support system.

Resident Interview Questionnaire – All of the interviewed residents reported that they could make a report either in person or in writing. They further stated that family and friends could make a report for them if needed.

115.251 (d). As reported in the PAQ, the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Staff can privately report by anonymous phone call, in writing to the PREA Coordinator, Department of Corrections or the State PREA Coordinator.

The employee handbook provides guidance on the staff ability to report.

Documentation Reviewed

Intake documents

Interviews

Random Sample of Staff- All of the interviewed staff reported they can privately report sexual abuse and sexual harassment of residents by notifying supervisor or Facility Director, send an email, or talk to them one-on-one closed door.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion:

Corrective Action: The resident handbook was missing some key information to inform residents of their rights on the agencies zero tolerance policy for sexual abuse and sexual harassment. During the post onsite audit phase, the handbook was updated. There is no further action needed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.252	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Findings (By Provision): 115.252 (a). The agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. 115.252 (b). The agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. 115.252 (c). The agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. 115.252 (d). The agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.252 (e). The agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. 115.252 (f). The agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. 115.252 (g). The agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.253	Resident access to outside confidential support services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Resident Access to Outside Confidential Support Services PREA Brochure (English/Spanish) YWCA New Britain Interviews: Resident Interview Questionnaire (10) Findings (By Provision): 115.253 (a). As reported in the PAQ, the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse. The facility provides residents with access to such services by giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations. The facility provides residents with access to such services by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. Policy: The Resident Access to Outside Confidential Support Services policy states that “Explaining to victims that there is help available to cope with the situation and attempt to provide the alleged victim a victim advocate from Connecticut Sexual Assault Services (CONNSACS) or, if none is available, arrange to have the alleged victim transported to Hartford Hospital or Hartford Correctional Center where qualified staff are on duty who have received education about sexual abuse and forensic examination issues. Attempts to provide services from CONNSACS shall be documented. CONNSACS shall, to the extent requested by the victim, be permitted to accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information and referrals. Providing clients with mailing addresses and telephone numbers, including toll free hotline numbers, of CONNSACS. Clients shall be allowed to be in communication with CONNSACS (or another victim’s advocate) in as confidential a manner as possible”. Documentation Reviewed PREA Brochure (English/Spanish) Interviews Resident Interview Questionnaire – Two of the ten residents reported that they were aware of outside services that deal with sexual abuse if needed. Only one could name a specific place. One reported that they were provided information from the facility but could not recall what it was; and the other resident reported the name of specific organizations. It was further reported that if they wanted to talk to the outside services they could on their own as they had their own cell phones. The residents felt that they could have a private conversation and felt that the entire conversation could remain private. PREA Audit Site Review: The auditor observed victim advocacy and supportive services information throughout the facility. Recommendation: The auditor recommended that the site add the victim advocacy and supportive information to the resident handbook. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.253 (b). As reported in the PAQ, the facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.

Policy: The Zero Tolerance states that “Offering to make arrangements for the victim to speak with their Clergy person(s)”.

During the Documentation Reviewed process, it was determined that the agency did not have policy language addressing the limitations to confidentiality. During the onsite inspection, the agency immediately updated its policy to include the language of the standard.

Corrective Action

Policy Update: The Resident Access to Outside Confidential Support Services states that “The Open Hearth provides residents with outside victim advocates for emotional support services related to sexual abuse by: Inform residents, prior to giving them access to outside support services, the extent to which the communication will be monitored”.

Documentation Reviewed

YWCA New Britain

Interviews

Resident Interview Questionnaire – Two of the ten interviewed residents reported being aware of outside services for sexual abuse. When asked if the conversation with the outside services could remain private the residents reported that the conversation would remain private, and both stated that the conversation could remain private.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.253 (c). As reported in the PAQ, the agency or facility maintains memorandum of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse.

The facility has an MOA with the YWCA New Britain. Upon review of the MOA with the Sexual Assault Crisis Center of Eastern Connecticut, it is found that the facility has a written agreement that the Sexual Assault Crisis Center of Eastern Connecticut can provide free, confidential and empowerment based sexual assault crisis and advocacy services including a 24-hour hotline, individual counseling, medical and legal accompaniment and support, and community education and training.

Documentation Reviewed

YWCA New Britain

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion:

115.253 (b)Policy Update: The Resident Access to Outside Confidential Support Services states that “The Open Hearth provides residents with outside victim advocates for emotional support services related to sexual abuse by: Inform residents, prior to giving them access to outside support services, the extent to which the communication will be monitored”. No further action is needed.

115.254	Third party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Third Party Reporting Website: CT PREA Statement – The Open Hearth Findings (By Provision): 115.254 (a). As reported in the PAQ, the agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The agency or facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. However, the policy provides a method to receive third party reports. Policy: The Third Parting Reporting Policy states that: “Staff shall accept reports of sexual abuse, sexual harassment, retaliation for reporting sexual abuse and harassment or staff neglect or violation of responsibilities from clients not directly involved in the incident in question. Such clients may report these incidents in any manner set forth below: 1. Reporting to any staff member either verbally or in writing (verbal reports must be documented promptly). 2. Writing a case manager request. 3. Writing an anonymous note. 4. Informing CTDOC. 5. Calling the Connecticut State Police. Staff shall also accept such reports from individuals outside the agency. These individuals may make reports by: 1. Writing to or calling agency officials stated on the agency’s website: The Executive Director or the PREA Coordinator. 2. Informing CTDOC. 3. Notifying the State Police. The above information shall be included on the agency website” Documentation Reviewed Website: CT PREA Statement – The Open Hearth Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.261	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Staff and Agency Reporting Duties Employee Handbook Interviews: Random Sample of Staff (12) Director or Designee PREA Coordinator Findings (By Provision): 115.261 (a). As reported in the PAQ, the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. The agency requires all staff to report immediately and according to agency policy retaliation against residents or staff who reported such an incident. The agency requires all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Policy: The Staff and Agency Reporting Duties states that: · All allegations of sexual misconduct or client-on-client sexual activity shall be reported to the PREA Coordinator within 2 hours. · Any staff that receives a report of sexual misconduct or possible sexual misconduct must ensure that it is immediately reported to their immediate supervisor whether or not it is part of the agency. The supervisor shall ensure that it is reported to the CT State Police if criminal in nature, the CTDOC and to the PREA Coordinator. Reports can be received verbally, in writing, anonymously, and from third parties. All verbal reports shall be documented promptly and reported accordingly. Apart from reporting to designated supervisors or officials and designated state or local services agencies, staff is prohibited from revealing any information related to a sexual misconduct, report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. While victims and complainants may report anonymously, staff that follow up to report the allegations shall not be afforded anonymous status. · All staff are required to immediately report any knowledge, suspicion, or information received regarding any incident that has occurred in the facility, retaliation against client's or staff who report sexual misconduct and any staff neglect or violation of responsibilities that may have contributed to an incident of sexual misconduct or retaliation to the PREA Coordinator or Executive Director. · Case Managers are required to report sexual misconduct to designated supervisors and the State Police if criminal in nature. Said staff members must inform residents at the initiation of services of their duty to report and the limitation of confidentiality. · Apart from reporting to designated supervisors and officials, all staff should only reveal information to those individuals who have a need-to-know basis to make treatment, investigate or other security and management decisions. Documentation Reviewed Employee Handbook Interviews Random Sample of Staff – All of the interviewed staff reported that everyone is required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have

contributed to an incident or retaliation. All staff reported similar policy/ procedure for reporting any information related to sexual abuse by notifying supervisor or Facility Director. Such report is supposed to be made immediately.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.261 (b). As reported in the PAQ, apart from reporting to designated supervisors or officials and designated state or local services agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Policy: The Staff and Agency Reporting Duties states that “Apart from reporting to designated supervisors and officials, all staff should only reveal information to those individuals who have a need-to-know basis to make treatment, investigate or other security and management decisions”.

Interviews

Random Sample of Staff – All of the interviewed staff reported that everyone is required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All staff reported similar policy/ procedure for reporting any information related to sexual abuse by notifying supervisor or Facility Director. Such report is supposed to be made immediately.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

15.261 (c). Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services. The facility does not have onsite medical and mental health staff.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.261 (d). If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws.

Interviews

Director or Designee – The interviewed staff reported that TOH does not have residents under 18. An allegation of abuse or harassment reported by someone considered a vulnerable adult would immediately be reported to CTDOC.

PREA Coordinator – The interviewed staff reported that TOH does not have residents under 18. An allegation of abuse or harassment reported by someone considered a vulnerable adult would immediately be reported to CTDOC.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.261 (e). The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

Interviews

Director or Designee The interviewed staff reported that all allegations of sexual harassment or abuse are immediately reported to the Connecticut Department of Corrections directly to the supervising Parole Officer during their on-duty hours or the DOC answering service if the report is received outside of business hours

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.262	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

The following evidence was analyzed in making compliance determination:

Supporting Documents, Interviews and Observations:

Pre-Audit Questionnaire (PAQ)

Policy: Agency Protection Duties

Interviews:

Agency Head

Director or Designee

Random Sample of Staff (12)

Findings (By Provision):

115.262 (a). As reported in the PAQ, when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay).

In the past 12 months, the number of times the agency or facility determined that a resident was subject to a substantial risk of imminent sexual abuse: 0.

If the agency or facility made such determinations in the past 12 months, the average amount of time (in hours) that passed before taking action: 0.

The longest amount of time (in hours or days) elapsed before taking action--if not "immediate" (i.e., without unreasonable delay). If not immediate, please explain in the comments section. N/A.

Policy: The Agency Protection Duties policy states that “The Open Hearth shall use screening information to enhance housing, bed, work, education and program assignments with the goal of keeping safe those clients at high risk of being sexually victimized. The agency will make individualized determinations on how to ensure the safety of each client. Information obtained through screening shall be kept confidential and only shared to the extent that it is necessary to do so to inform treatment plans, security and management decisions (including housing, bed, work, education and program assignments) or as otherwise required by Federal, State or local law”.

Interviews

Agency Head – The interviewed staff reported that within reason, special accommodations will be made for the person within TOH setting. This could include (but is not limited to) bed assignment, separate toilet, separate shower facilities, special chore assignment. If it is determined that TOH cannot meet the needs of the resident CTDOC will be consulted regarding a more appropriate assignment for the individual.

Director or Designee – The interviewed staff stated that all allegations of sexual harassment or abuse are immediately reported to the Connecticut Department of Corrections directly to the supervising Parole Officer during their on-duty hours or the DOC answering service if the report is received outside of business hours

Random Sample of Staff: The interviewed staff reported that when they learn that a resident is at risk of imminent sexual abuse the actions taken to protect the residents include remove resident from the threat, keep involved parties separated, monitor, report, and document. Such actions would be taken immediately.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.263	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reporting to other Confinement Facilities Interviews: Agency head Director or designee Findings (By Provision): 115.263 (a). As reported in the PAQ, the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. During the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: 0. Policy: The Reporting to other Confinement Facilities states that “Upon receiving an allegation that a resident was sexually abused while confined at another facility, The Director of Operations of the Open Hearth will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.263 (b). As reported the PAQ, the Agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. Policy: The Reporting to other Confinement Facilities states that “Such notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.263 (c). As reported in the PAQ, the agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. Policy: The Reporting to other Confinement Facilities states that “Such notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.263 (d). As reported in the PAQ, the agency or facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: 0. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: Policy: The Reporting to other Confinement Facilities states that “Upon receiving an allegation that a resident was sexually abused while confined at another facility, The Director of Operations of the Open Hearth will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred”. Interviews Agency head -The interviewed staff reported that allegations of sexual harassment or abuse are immediately reported to the Connecticut Department of Corrections directly to the supervising Parole Officer during their on-duty hours or the DOC answering service if the report is received outside of business hours. Allegations of sexual harassment or abuse are

	immediately reported to the Connecticut Department of Corrections directly to the supervising Parole Officer during their on-duty hours or the DOC answering service if the report is received outside of business hours. There have been no such allegations being reported from another agency or facility. Director or designee – The interviewed staff stated that if the facility receives an allegation from another agency that an incident of sexual abuse or sexual harassment occurred at the facility, it would immediately be reported to the Connecticut Department of Corrections directly to the supervising Parole Officer during their on-duty hours or the DOC answering service if the report is received outside of business hours. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.264	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Official Response Following a Resident Report Interviews: Security Staff and Non-Security Staff First Responders Residents who Reported a Sexual Abuse Findings (By Provision): 115.264 (a). As reported in the PAQ, the agency has a first responder policy for allegations of sexual abuse. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to separate the alleged victim and abuser. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. The policy requires that, upon learning of an allegation that a resident was sexually abused and the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report shall be required to request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The policy requires that, upon learning of an allegation that a resident was sexually abused and the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report shall be required to ensure that the alleged abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. In the past 12 months, the number of allegations that a resident was sexually abused: 0 Of these allegations, the number of times the first security staff member to respond to the report separated the alleged victim and abuser: 0 In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report preserved and protected any crime scene until appropriate steps could be taken to collect any evidence: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report requested that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report ensured that the alleged abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating: 0. Policy: The Official Response Following a Resident Report policy states that: Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report will be required to: 1. Separate the alleged victim and abuser. 2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. 3. If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged

abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.

4. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

Interviews

Random Sample of Staff/ Security Staff and Non-Security Staff First Responders: The interviewed staff reported that if they are the first person on the scene and they have been alerted to have been a victim of sexual abuse, it is there responsibility to make sure the victim is safe, keep involved parties separated, contact their chain of command, don't allow them to drink, brush teeth, or shower, and preserve the crime scene. When probed staff reported that they would only share with the supervisors.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.264 (b). As reported in the PAQ, the agency policy does not require that if the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence. Agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to notify security staff.

Of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: 0.

Of those allegations responded to first by a non-security staff member, the number of times that staff member requested that the alleged victim not take any actions that could destroy physical evidence: N/A.

Of those allegations responded to first by a non-security staff member, the number of times that staff member notified security staff: N/A.

Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report will be required to:

1. Separate the alleged victim and abuser.

2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence.

3. If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.

4. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

Interviews

Random Sample of Staff/ Security Staff and Non-Security Staff First Responders: The interviewed staff reported that if they are the first person on the scene and they have been alerted to have been a victim of sexual abuse, it is there responsibility to make sure the victim is safe, keep involved parties separated, contact their chain of command, don't allow them to drink, brush teeth, or shower, and preserve the crime scene. When probed staff reported that they would only share with the supervisors.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

Corrective Action and Conclusion:

The following evidence was analyzed in making compliance determination:

Supporting Documents, Interviews and Observations:

Pre-Audit Questionnaire (PAQ)

Policy: Reporting to other Confinement Facilities

Interviews:

Agency head

Director or designee

Findings (By Provision):

115.263 (a). As reported in the PAQ, the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. During the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: 0.

Policy: The Reporting to other Confinement Facilities states that “Upon receiving an allegation that a resident was sexually abused while confined at another facility, The Director of Operations of the Open Hearth will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred”.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.263 (b). As reported the PAQ, the Agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation.

Policy: The Reporting to other Confinement Facilities states that “Such notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation”.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.263 (c). As reported in the PAQ, the agency or facility documents that it has provided such notification within 72 hours of receiving the allegation.

Policy: The Reporting to other Confinement Facilities states that “Such notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation”.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.263 (d). As reported in the PAQ, the agency or facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities:

0.

In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities:

Policy: The Reporting to other Confinement Facilities states that “Upon receiving an allegation that a resident was sexually abused while confined at another facility, The Director of Operations of the Open Hearth will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred”.

Interviews

Agency head -The interviewed staff reported that allegations of sexual harassment or abuse are immediately reported to the Connecticut Department of Corrections directly to the supervising Parole Officer during their on-duty hours or the DOC answering service if the report is received outside of business hours. Allegations of sexual harassment or abuse are immediately reported to the Connecticut Department of Corrections directly to the supervising Parole Officer during their on-duty hours or the DOC answering service if the report is received outside of business hours. There have been no such allegations being reported from another agency or facility.

Director or designee – The interviewed staff stated that if the facility receives an allegation from another agency that an incident of sexual abuse or sexual harassment occurred at the facility, it would immediately be reported to the Connecticut Department of Corrections directly to the supervising Parole Officer during their on-duty hours or the DOC answering service if the report is received outside of business hours.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion:

	A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.265	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Coordinated Response Interviews: Director Findings (By Provision): 115.265 (a). As reported in the PAQ, the facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Policy: The Coordinated Response policy states that “The PREA Coordinator will ensure that a coordinated response is in place when allegations of sexual abuse are reported. This includes the written facility plan of actions taken in response to an incident of sexual abuse, among staff, first responders, medical and mental health practitioners, investigators, and facility leadership. 2. First responders will follow with: a. Proper notification to the PREA Coordinator, Executive Director, and the CTDOC assigned Parole Officer. b. For criminal investigations the CT State Police will be notified. c. Community mental health providers are notified if required or requested. d. Proper community victim advocate services are initiated if requested or required. e. Proper medical services are initiated if requested or required”. Interviews Director or Designee – The interviewed staff reported that all staff are trained to fully cooperate with all parties that are involved in the investigation of a PREA incident and with caregivers for victims. TOH does not employ “medical and mental health practitioners, investigators”. Thus, no coordination is called for. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.266	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Interviews: Agency Head Findings (By Provision): 115.266 (a). The agency, facility, or any other governmental entity is not responsible for collective bargaining on the agency's behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. Interviews Agency Head – The interviewed staff reported that TOH has not entered into any collective bargaining agreements. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.266 (b). N/A- Auditor is not required to audit this provision. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.267	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Agency Protection Duties Retaliation Interviews: Agency Head Director or Designee Designated Staff Member Charged with Monitoring Retaliation (or Director if none available) Residents who Reported a Sexual Abuse Findings (By Provision): 115.267 (a). As reported in the PAQ, the agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency designates staff member(s) or charges department(s) with monitoring for possible retaliation. Policy: The Agency Protection Duties Retaliation policy states that" No resident or staff should be retaliated against for reporting client sexual abuse or client sexual harassment. For at least 90 days following a report of sexual abuse the PREA Coordinator shall monitor the conduct and treatment of inmates or staff who reported the alleged sexual abuse and of clients who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by clients or staff and shall act promptly to remedy any such retaliation. Items the PREA Coordinator should monitor include any inmate disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The PREA Coordinator should also include periodic status checks of any alleged client victims. The PREA Coordinator shall continue the monitoring beyond 90 days if the initial monitoring indicates a continuing need for monitoring. If any other individual who cooperates with the investigation expresses a fear of retaliation, the PREA Coordinator shall recommend appropriate actions (if any) to protect the individual against retaliation. The agencies PREA Coordinator's obligation to monitor shall terminate if an investigation determines that the allegation is unfounded". Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.267 (b). As reported in the PAQ, the agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. Interviews Agency Head – The interviewed staff reported that first of all, abusers are removed by the CTDOC. For at least 90 days following a report of sexual abuse the PREA Coordinator monitors the conduct and treatment of residents or staff who reported the sexual abuse or harassment of clients to see if there are changes that may suggest possible retaliation by clients or staff. If retaliation were suspected (due either to observations or reporting) we would immediately contact the Supervising PO. A discussion would be conducted as to the best steps to protect the resident. This could include (but not limited to) the removal of other residents, transfer of the reporter to another halfway house, termination/suspension of staff. Director or Designee – The interviewed staff reported that for allegations of sexual abuse or sexual harassment, the different measures taken to protect residents and staff from retaliation include: CTDOC would be immediately notified in the event that retaliation was occurring or being attempted. In addition, all appropriate actions necessary to protect the target(s) of retaliation. Including but not limited to adjusting staffing patterns, electronic monitoring, staff rounds, housing assignments, and intake procedures. Designated Staff Member Charged with Monitoring Retaliation (or Director if none available) – The interviewed staff reported that it would be their responsibility to monitor the conduct and treatment of residents or staff who reported alleged sexual

abuse and of clients who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by clients or staff and shall act promptly to remedy any such retaliation. Job, supervisory, and shift assignments would be considered in the case of staff. In the case of residents, housing/bed, sanitary facilities, chores and case management assignments would be considered but considerations would not be limited to these considerations. Placement at another facility would also be considered if it were determined that no reasonable measures could be taken to ensure the resident's safety at the program. Contact would be initiated and continue for at least 90 days or as long as the resident is in the program.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

15.267 (c). As reported in the PAQ, the agency/facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The agency/facility continues such monitoring the length of stay.

The number of times an incident of retaliation occurred in the past 12 months: 0.

Policy: The Agency Protection Duties Retaliation policy states that "The PREA Coordinator should also include periodic status checks of any alleged client victims. The PREA Coordinator shall continue the monitoring beyond 90 days if the initial monitoring indicates a continuing need for monitoring. If any other individual who cooperates with the investigation expresses a fear of retaliation, the PREA Coordinator shall recommend appropriate actions (if any) to protect the individual against retaliation. The agencies PREA Coordinator's obligation to monitor shall terminate if an investigation determines that the allegation is unfounded".

Interviews

Director or Designee – The interviewed staff stated that to date there have not been any cases of sexual abuse to address. However, if there were CTDOC would be immediately notified in the event that retaliation was occurring or being attempted. In addition, all appropriate actions necessary to protect the target(s) of retaliation. Including but not limited to adjusting staffing patterns, electronic monitoring, staff rounds, housing assignments, and intake procedures.

Designated Staff Member Charged with Monitoring Retaliation (or Director if none available) – The interviewed staff reported that when they are looking for possible signs of retaliation the monitoring would include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. I would also periodically perform status checks of any alleged client victims. The monitoring would occur for at least 90 days. However, the monitoring will continue beyond 90 days if the initial monitoring indicates a continuing need for monitoring. If there is concern for possible retaliation the staff member reported that they would monitor for as long as deemed appropriate to ensure the safety of the residents or staff. Monitoring would occur as long as the optional existed for retaliation or for as long as the victim remained at the program.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.267 (d). In the case of residents, such monitoring shall also include periodic status checks.

Interviews

Designated Staff Member Charged with Monitoring Retaliation (or Director if none available) – The interviewed staff reported that areas that we would look to detect possible retaliation include reviewing any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. I would also periodically perform status checks of any alleged client victims.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.267 (e). If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.

Interviews

Agency Head – The interviewed staff reported that if an individual voiced concerns about retaliation we would immediately contact the Supervising PO. A discussion would be conducted as to the best steps to protect the individual. This could include (but not limited to) the removal of other residents, transfer of the reporter to another halfway house, termination/suspension of staff.

Director or Designee – The interviewed staff stated that to date there have not been any cases of sexual abuse to address. However, if there were CTDOC would be immediately notified in the event that retaliation was occurring or being attempted.

	In addition, all appropriate actions necessary to protect the target(s) of retaliation. Including but not limited to adjusting staffing patterns, electronic monitoring, staff rounds, housing assignments, and intake procedures. In addition, all appropriate actions necessary to protect the target(s) of retaliation. Including but not limited to adjusting staffing patterns, electronic monitoring, staff rounds, housing assignments, and intake procedures. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.267 (f). N/A the auditor is not required to audit this provision. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.271	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act (PREA) Policy Synopsis Interviews: Director or Designee PREA Coordinator Investigative Staff Findings (By Provision): 115.271 (a). As reported in the PAQ, the agency/facility has a policy related to criminal and administrative agency investigations. Policy: The Prison Rape Elimination Act (PREA) Policy Synopsis policy states that: Investigations: · The CT State Police & the Connecticut Department of Corrections handle the investigation involving men in the custody of CTDOC in Connecticut. Staff are expected to cooperate with the investigation. Interviews Investigative Staff – The outside interviewed investigator reported that fact gathering preliminary investigations (Incident Reports) are immediately initiated at the facility. Those resulting in Administrative Investigations are normally completed within 60 days. Anonymous reports are handled in the same manner and priority as any other reported allegation. They are also investigated the same way. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.271 (b). As reported in the PAQ, the agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. Interviews Investigative Staff – The outside interviewed investigator reported that they have received training specific to conducting sexual abuse investigations. The training is online through the PREA Resource Center "Your Role in Responding to Sexual Abuse" and "Investigating Sexual Abuse in a Confinement Setting". Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.271 (c). Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. Investigative Staff - The outside interviewed investigator reported that the first steps in initiating an investigation. The steps include separation of victim and abusers. Preserving evidence. Provide services. These are initiated immediately following an allegation. Completed incident reports are forwarded to agency's PREA Coordinator for review and recommendations. When Agency Head or Designee authorize an administrative investigation, a case number is generated and completed package assigned to a PREA Unit Investigator for final findings. Time between reporting and assignments vary based on administration reviews and/or pending criminal disposition. The investigation process states that incidents are forwarded up the chain of command and authorized for investigation by

the PREA Unit. Additional statements and interviews are then gathered and conducted with parties involved. Referrals to CSP made for allegations that appear to be criminal. Findings are concluded and investigation submitted to administration for approval. Closure and findings notifications made to parties involved.

Direct and circumstantial evidence includes the following: Direct physical evidence (clothing or DNA) will be collected at the facility by staff or CSP along with hospital personnel. Statements, video recordings, interviews, historical information regarding prior allegations not yet obtained will be gathered during investigation.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.271 (d). When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Interviews

Investigative Staff – The outside interviewed investigator reported that they have received training specific to conducting sexual abuse investigations. The training is online through the PREA Resource Center "Your Role in Responding to Sexual Abuse" and "Investigating Sexual Abuse in a Confinement Setting".

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.271 (e). The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. However it should be noted that law enforcement would conduct the interviews.

Interviews

Investigative Staff - The outside interviewed investigator reported that the credibility of an alleged victim, suspect, or witness is done specifically for that person, and not by whether he or she is an inmate or a staff member. Inmates are not subject to polygraph test. The investigation will move forward regardless of whether a polygraph is undergone.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.271 (f). Administrative investigations: (1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

Investigative Staff – The interviewed staff reported that the following efforts are made during the administrative investigation to determine whether staff actions or failures to act contributed to the sexual abuse states that the reviews are submitted incident reports and conduct interviews to determine if any actions or lack of actions contributed to the sexual abuse. Facts gathered from incident reports, interviews and statements, video recordings. Findings of allegations along with recommendations if warranted.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard

115.271 (g). Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

Interviews

Investigative Staff – The outside interviewed investigator reported that criminal investigations are documented and kept with Connecticut State Patrol (CSP) only.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.271 (h). As reported in the PAQ, substantiated allegations of conduct that appear to be criminal are referred for prosecution. There were zero number of substantiated allegations of conduct that appear to be criminal that were referred for

prosecution since the last PREA audit. The number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012, or since the last PREA audit, whichever is later: 0.

Interviews

Investigative Staff - The outside interviewed investigator reported that referrals for prosecution are made by CSP.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.271 (i). As reported in the PAQ, the agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual assault or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

Policy: The Prison Rape Elimination Act (PREA) Policy Synopsis policy states that “the facility shall ensure that records are maintained as per CTDOC Directive 6.12”.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.271 (j). The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

Interviews

Investigative Staff - The outside interviewed investigator reported that Investigation still moves forward despite the employee’s employment status.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

115.271 (k). Auditor is not required to audit this provision.

115.271 (l). When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

Interviews

Director or Designee – The interviewed staff report that if an outside agency investigates allegations of sexual abuse, TOH is in constant and consistent contact with CTDOC with the primary contact being the supervising PO.

PREA Coordinator – The interviewed PREA Coordinator reported that if an outside agency investigations allegation of sexual abuse the program TOH is in constant contact with CTDOC and CTDOC will communicate directly to the resident or inform TOH staff who will communicate with the client. In the case of the State or local police, upon request from the resident TOH staff will either facilitate direct contact between the resident and police or get the information from the police and inform the client. Upon the resident’s discharge from the program TOH’s obligation to inform ceases.

Investigative Staff - The outside interviewed investigator reported that they conduct investigations for the contracted Community Confinement Sites. It was further reported that if state patrol conducts the investigation, they will assist CSP in whatever capacity is requested. Coordinating interviews. Provide movement information on involved parties. Act as a liaison for information.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.272	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Interviews: Investigative Findings (By Provision): 115.272 (a). As reported in the PAQ, the agency does not impose a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse of sexual harassment are substantiated. The facility does not conduct the investigation. Interviews Investigative Staff – The interviewed investigator reported that a preponderance of evidence is used to determine whether an incident was more likely to have occurred. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.273	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reporting to Residents Interviews: Director Investigative Staff Findings (By Provision): 115.273 (a). As reported in the PAQ, the agency has a policy requiring that any resident who alleges that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility in the past 12 months: 0. Of the alleged sexual abuse investigations that were completed in the past 12 months, the number of residents who were notified, verbally or in writing, of the results of the investigation: N/A. Policy: The Reporting to Residents policy states that “Following an investigation into a client’s allegation that he suffered sexual abuse, the PREA Coordinator shall inform the client when an allegation is found to be substantiated. If the allegation was of a criminal nature then the PREA Coordinator shall request from the State Police the relevant information in order to inform the client”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.273 (b). As reported in the PAQ if an outside entity conducts the investigation, the agency will request the relevant information from the investigation entity in order to inform the resident of the outcome of the investigation. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months: 0 Of the outside agency investigations of alleged sexual abuse that were completed in the past 12 months, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigation: N/A no investigations by the outside agency. Policy: The Reporting to Residents policy states that “Following an investigation into a client’s allegation that he suffered sexual abuse, the PREA Coordinator shall inform the client when an allegation is found to be substantiated. If the allegation was of a criminal nature then the PREA Coordinator shall request from the State Police the relevant information in order to inform the client”. Interviews Director or Designee – The interviewed staff reported that following an investigation into a client’s allegation that he suffered sexual abuse, the PREA Coordinator shall inform the client when an allegation is found to be substantiated. If the allegation was of a criminal nature, then the PREA Coordinator shall request from the State Police the relevant information in order to inform the client. Investigative Staff – The interviewed investigator reported that inmates are informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.273 (c). As reported in the PAQ, following a residents allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless unfounded) whenever:

§ The staff member is no longer posted within the residents unit;

§ The staff member is no longer employed at the facility;

§ The agency learns that the staff member has been indicated on a charge related to sexual abuse within the facility; or

§ The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Policy: The Reporting to Residents policy states that "Following an client's allegation that a staff member has committed sexual abuse against the client, the agency shall subsequently inform the client (unless the allegation has been determined to be unfounded or unsubstantiated) whenever:

(1) the staff member is no longer employed by the agency;

(2) the agency learns that the staff member has been arrested on a charge related to sexual abuse within the agency; or

(3) the agency learns that the staff member has been convicted on a charge related to sexual abuse within the agency".

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.273 (d). As reported in the PAQ, the following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whomever the agency learns that the alleged abuser has been indicated on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Policy: The Reporting to Residents policy states that "Following a client's allegation that he or she has been sexually abused by another client, the agency shall inform the alleged victim whenever:

(1) the agency learns that the alleged abuser has been arrested on a charge related to sexual abuse in the agency; or

(2) the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the agency".

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.273 (e). As reported in the PAQ, the agency has a policy that all notifications to residents described under this standard are documented. In the past 12 months, the number of notifications to residents that were provided pursuant to this standard: 0.

Of those notifications made in the past 12 months, the number that were documented: 0.

Policy: The Reporting to Residents policy states that "All such notifications shall be documented in the resident's master file. The agency's obligation to report under this standard shall terminate if the alleged victim is discharged from the agency".

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.273 (f). The auditor is not required to audit this provision of the standard.

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.276	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Disciplinary Sanctions for Staff Interviews: Agency Head PREA Coordinator Warden Findings (By Provision): 115.276 (a). As reported in the PAQ, staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Policy: The Disciplinary Sanctions for Staff policy states that “Staff shall be subject to disciplinary sanctions up to and including termination for violating agency client sexual abuse and/or harassment policies. Termination is the presumptive disciplinary sanction for staff that has been found to have engaged in sexual abuse. All terminations for violations of agency client sexual abuse or harassment policies or resignations by staff who would have been terminated but for their resignation shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.276 (b). Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. In the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies: 0. In the past 12 months, the number of staff from the facility who have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: 0. Policy: The Disciplinary Sanctions for Staff policy states that “Termination is the presumptive disciplinary sanction for staff that has been found to have engaged in sexual abuse. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.276 (c). As reported in the PAQ, the disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. In the past 12 months, the number of staff from the facility who have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse): 0. During the documentation review phase, it was determined that the agency did not have policy language to address the provision. During the onsite phase, the agency immediately updated its policy to reflect the requirements of the provision. Policy Update: The Disciplinary Sanctions for Staff policy states that “The disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed., the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.276 (d). As reported in the PAQ, all terminations for violations of agency sexual abuse or sexual harassment policies, or

	resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies. In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: 0. Policy: The Disciplinary Sanctions for Staff policy states that "All terminations for violations of agency client sexual abuse or harassment policies or resignations by staff who would have been terminated but for their resignation shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies". Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: Corrective Action and Conclusion: Corrective Action: 115.276 (c). During the documentation review phase, it was determined that the agency did not have policy language to address the provision. During the onsite phase, the agency immediately updated its policy to reflect the requirements of the provision. There is no further action needed.

115.277	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Corrective Action for Contractors and Volunteers Interviews: Director or Designee Findings (By Provision): 115.277 (a). As reported in the PAQ, the Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents: 0. In the past 12 months, the number of contractors or volunteers reported to law enforcement for engaging in sexual abuse of residents: 0. Policy: The Corrective Action for Contractors and Volunteers states that “Any contractor, vendor or volunteer who engages in sexual abuse shall be prohibited from contact with clients and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.277 (b). As reported in the PAQ, the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Policy: The Corrective Action for Contractors and Volunteers states that “TOH shall take appropriate remedial measures and shall consider whether to prohibit further contact with inmates, in the case of any other violation of agency client sexual abuse or sexual harassment policies by a contractor or volunteer”. Interviews Director or Designee – The interviewed staff reported that they have not had any violations of agency sexual abuse or sexual harassment by a contractor or volunteer. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.278	Disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Disciplinary Sanctions for Residents Interviews: Director or Designee Findings (By Provision): 115.278 (a). As reported in the PAQ, residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. In the past 12 months, the number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: 0. In the past 12 months, the number of criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility: 0. Policy: The Disciplinary Sanctions for Residents states that “Findings that a resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident abuse sexual will result in immediate removal by CTDOC from the facility. Further disciplinary sanctions will be determined by CTDOC”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard 15.278 (b). Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. Interviews Director or Designee – The interviewed staff reported that CTDOC would determine any disciplinary actions. That would not be the responsibility of TOH. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.278 (c). The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Interviews Director or Designee – The interviewed staff reported that CTDOC would determine any disciplinary actions. That would not be the responsibility of TOH. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.278 (d). As reported in the PAQ, the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.278 (e). As reported in the PAQ, the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

Policy: The Disciplinary Sanctions for Residents states that “Findings that a resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident abuse sexual will result in immediate removal by CTDOC from the facility. Further disciplinary sanctions will be determined by CTDOC”.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.278 (f). For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Policy: The Disciplinary Sanctions for Residents states that “Findings that a resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident abuse sexual will result in immediate removal by CTDOC from the facility. Further disciplinary sanctions will be determined by CTDOC”.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.278 (g). The agency prohibits all sexual activity between residents and the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Policy: The Zero Tolerance policy states that “The Open Hearth has a zero tolerance for any acts of sexual abuse, assault, misconduct or harassment. Sexual activity between staff, volunteers or contracted personnel and clients, as well as between client and client is prohibited and subject to administrative and criminal disciplinary sanctions. The Open-Hearth staff shall take prudent measures to ensure the safety of both clients and staff”.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.282	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Access to Emergency Medical and Mental Health Services Interviews: Security staff and non-security staff first responders (12) Findings (By Provision): 115.282 (a). As reported in the PAQ, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. The facility does not have onsite medical and mental healthcare. Policy: The Access to Emergency Medical and Mental Health Services policy states that “The agency shall immediately offer medical and mental health evaluation at Hartford Hospital, The University of Connecticut Medical Center or Hartford Correctional Center to resident victims of sexual abuse. Also, as appropriate, treatment to all clients who have been victimized by sexual abuse in any facility. (A client may refuse such treatment in writing utilizing HR-301; Refusal of Health Services) any such refusal must be documented by the staff person”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.282 (b). N/A The agency does not employ medical or mental health staff. Interviews Random Sample of Staff/ Security Staff and Non-Security Staff First Responders: The interviewed staff reported that if they are the first person on the scene and they have been alerted to have been a victim of sexual abuse, it is there responsibility to make sure the victim is safe, keep involved parties separated, contact their chain of command, don’t allow them to drink, brush teeth, or shower, and preserve the crime scene. When probed staff reported that they only share the information with the supervisory staff. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 111.282 (c). N/A-As reported in the PAQ. Interviews Random Sample of Staff/ Security Staff and Non-Security Staff First Responders: The interviewed staff reported that if they are the first person on the scene and they have been alerted to have been a victim of sexual abuse, it is there responsibility to make sure the victim is safe, keep involved parties separated, contact their chain of command, don’t allow them to drink, brush teeth, or shower, and preserve the crime scene. When probed staff reported that they only share the information with the supervisory staff. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.282 (d). As reported in the PAQ, treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Policy: The Access to Emergency Medical and Mental Health Services policy states that “The medical/mental health services shall be provided to the client, at no financial cost, whether he names the abuser cooperates with any investigation arising out of the incident or not”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the

	facility is in compliance with the provisions of this standard.: Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.283	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Ongoing medical and mental health care for sexual abuse victims and abusers Interviews: Findings (By Provision): 115.283 (a). The facility does offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Policy: The Ongoing medical and mental health care for sexual abuse victims and abusers' policy states that “The agency shall immediately offer medical and mental health evaluation at Hartford Hospital, The University of Connecticut Medical Center or Hartford Correctional Center to resident victims of sexual abuse. Also, as appropriate, treatment to all clients who have been victimized by sexual abuse in any facility. (An client may refuse such treatment in writing utilizing HR-301; Refusal of Health Services) any such refusal must be documented by the staff person”. PREA Audit Site Review: Make observations and ask questions per the tour instructions. Note observations, etc. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.283 (b). The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Policy: The Ongoing medical and mental health care for sexual abuse victims and abusers' policy states that “The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.283 (c). The facility shall provide such victims with medical and mental health services consistent with the community level of care. Policy: The Ongoing medical and mental health care for sexual abuse victims and abusers' policy states that “The agency shall ensure that victims receive medical and mental health services consistent with the community level of care”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.283 (d). NA-the facility only houses male residents. 115.283 (e). NA-the facility only houses male residents 115.283 (f). Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. The agency does not provide treatment services onsite all services will be referred for offsite medical care. Policy: The Ongoing medical and mental health care for sexual abuse victims and abusers' policy states that t “Client victims of sexual abuse while incarcerated shall be offered timely access to information about and access to sexually transmitted infections prophylaxis and tests for sexually transmitted infections all as medically appropriate. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.283 (g). Treatment services shall be provided to the victim without financial cost and regardless of whether the victim

	names the abuser or cooperates with any investigation arising out of the incident. Policy: The Ongoing medical and mental health care for sexual abuse victims and abusers' policy states that “Treatment services relative to sexual abuse shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.283 (h). The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. Policy: The Zero Tolerance states that “CTDOC policy states it will conduct mental health evaluation within 60 days on all known resident-on-resident abusers” (p. 12). Documentation Reviewed Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.286	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Sexual Abuse Incident Reviews Memo: Incident Review Team Training Interviews: Incident Review Team (2) Director Findings (By Provision): 115.286 (a). As reported in the PAQ, the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents: 0. Policy: The Sexual Abuse Incident Reviews policy states that "TOH shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation unless the incident has been determined to be unfounded". Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.286 (b). As reported in the PAQ, the facility does not ordinarily conduct a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility that were followed by a sexual abuse incident review within 30 days, excluding only "unfounded" incidents: 0. Policy: The Sexual Abuse Incident Reviews policy states that "The review shall ordinarily occur within 30 days of the conclusion of the investigation". Policy: Prison Rape Elimination ACT Policy Synoposis states that "Sexual Misconduct Review and Review Team: The facility shall conduct a sexual misconduct incident review at the conclusion of every sexual misconduct investigation, including those where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. This review shall ordinarily be conducted within thirty (30) days of the conclusion of the investigation by a Review Team. The facility shall create a Review Team that consists of: · PREA Coordinator. · Relevant Associate Counselor staff. · Executive Director. · Director of Client Services. · House Manager. The Review Team shall: · Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual misconduct. · Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.

· Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.

· Assess the adequacy of staffing levels in that area during different shifts.

· Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

· Prepare a report of the Team findings, including but not necessarily limited to items 1-5 above, and any recommendations for improvement and submit such report to the CTDOC PREA Coordinator, The report shall include recommendations for improvement. All recommendations shall be implemented, or justification provided for not implementing said recommendations (pp. 7-8).

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.286 (c). The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

Policy: The Sexual Abuse Incident Reviews policy states that “The review team shall include upper-level management officials, with input from line supervisors, investigators and medical or mental health practitioners”.

Interviews

Director or Designee – The interviewed staff reported that to date there have been no allegations of sexual harassment or abuse. Thus, there have been no incidents to review. If an incident did occur TOH would conduct a sexual abuse incident review at the conclusion of the abuse investigation unless the incident was determined to be unfounded. The review would occur immediately upon being informed by the investigatory entity of the results of the investigation. The review team would include myself, supervisors, frontline workers and appropriate consultants.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.286 (d). As reported in the PAQ, the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator.

Policy: The Sexual Abuse Incident Reviews policy states that “The review team shall:

(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;

(2) Consider whether the incident or allegation was motivated by race, ethnicity, gang affiliation, gender identity, status or perceived status as lesbian, gay, bisexual or intersex, or was motivated or otherwise caused by other group dynamics at the agency;

(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;

(4) Assess the adequacy of staffing levels in that area during different shifts;

(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and

(6) Prepare a report of its findings, including but not necessarily limiting the report to the areas laid out herein as well as any recommendations for improvement. The report shall be submitted to the Executive Director and the PREA Coordinator.

Interviews

Director or Designee – The interviewed staff reported that the team uses information from the sexual abuse incident review based on the findings of the report all appropriate actions would be taken. Including but not limited to adjusting staffing patterns, electronic monitoring, staff rounds, housing assignments, and intake procedures. To date TOH has not had a reason to convene a review team. Should the need arise the review team would endeavor to consider any underlying motivational factors and all factors relating to the structural environment. The Open-Hearth program TOH has a commitment to evaluate the effectiveness of our staffing patterns on an ongoing basis.

PREA Coordinator – The interviewed staff reported that they would be a part of the incident review process. To date there have been no allegations of sexual harassment or abuse. Thus, there have been no incidents to review. If an incident did occur TOH would conduct a sexual abuse incident review at the conclusion of the abuse investigation unless the incident was determined to be unfounded. The review would occur immediately upon being informed by the investigatory entity of the

results of the investigation. The review team would include myself, supervisors, frontline workers and appropriate consultants. Based on the findings of the report any and all appropriate actions. Including but not limited to adjusting staffing patterns, electronic monitoring, staff rounds, housing assignments, and intake procedures.

Incident Review Team – The interviewed staff on the incident review team reported that they have never had an incident occur. The policy states what to do, but we have never had to do anything. One staff further reported that since they have never experienced an allegation, they wouldn't know what to do. However, we have team meetings to address other things and if its PREA related it goes straight to DOC.

Corrective Action: The interviewed staff was not comfortable articulate the requirements of the Incident Review process. The facility staff have not had to respond to a sexual abuse allegation. The auditor recommended that the facility leadership conduct a tabletop exercise or training with the assigned incident review team staff to ensure that they are aware of the requirements of the review team. The facility provided a memo dated 6/9/2022 indicating that "TOH will begin conducting Incident Review Training shortly after the return of the Director of Resident Service from his previously planned vacation. As you aware TOH has never had an accusation of sexual abuse or harassment. Thus, we have no experience at reacting to an accusation. To facilitate reacting in an appropriate and timely fashion in the event of an accusation we are planning to do trainings. These trainings will consist of having mock reviews of various scenarios of sexual harassment and abuse" The team will include, but not be limited to myself, Mr. McFolley, Case Managers, and the Associate Counselor's Supervisor.

115.286 (e). The facility implements the recommendations for improvement or documents its reasons for not doing so.

Policy: The Sexual Abuse Incident Reviews policy states that "The agency shall implement the recommendations for improvement or shall document its reasons for not doing so".

Corrective Action and Conclusion:

Corrective Action: 115.286 (d). The interviewed staff was not comfortable articulate the requirements of the Incident Review process. The facility staff have not had to respond to a sexual abuse allegation. The auditor recommended that the facility leadership conduct a tabletop exercise or training with the assigned incident review team staff to ensure that they are aware of the requirements of the review team. The facility provided a memo dated 6/9/2022 indicating that "TOH will begin conducting Incident Review Training shortly after the return of the Director of Resident Service from his previously planned vacation. As you aware TOH has never had an accusation of sexual abuse or harassment. Thus, we have no experience at reacting to an accusation. To facilitate reacting in an appropriate and timely fashion in the event of an accusation we are planning to do trainings. These trainings will consist of having mock reviews of various scenarios of sexual harassment and abuse" The team will include, but not be limited to myself, Mr. McFolley, Case Managers, and the Associate Counselor's Supervisor.

115.287	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Data Collection 2021 PREA Data Report Interviews: Findings (By Provision): 115.287 (a). As reported in the PAQ, the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Policy: The Data Collection and Review policy states that “TOH shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using standardized instrument and set definitions”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.287 (b). The agency shall aggregate the incident-based sexual abuse data at least annually. Policy: The Data Collection policy states that “TOH will aggregate the incident based sexual abuse data at least annually. Documentation Reviewed 2021 PREA Data Report Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.287 (C). As reported in the PAQ, the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. Policy: The Data Collection policy states that “The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice”. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.287 (d). N/A-The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Policy: The Data Collection policy states that “TOH will maintain, review, and collect data as needed from all available incident based documents, including reports, investigation files, and sexual abuse incident reviews”. Documentation Reviewed 2021 PREA Data Report Interviews Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.287 (e). N/A the agency does not contract for the confinement of its residents. 115.287 (f). N/A the DOJ has not requested agency data. However, the Data Collection policy states that “Upon request, OH shall provide all such data from the previous calendar year to the Department of Justice no later than June 30th”.

	Corrective Action and Conclusion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.288	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Data Review for Corrective Action 2021 PREA Data Report Website: CT PREA Statement – The Open Hearth Interviews: Agency Head PREA Coordinator Findings (By Provision): 115.288 (a). As reported in the PAQ, the agency reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including: (a) identifying problem areas; (b) taking corrective action on an ongoing basis; and (c) preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. Policy: Data Review for Corrective Action states that "TOH will review data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. Including: 1. Identifying problems areas. 2. Taking corrective action on identified problem areas. 3. Preparing an annual report of its findings and corrective actions. 4. Said report will include comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse. 5. The agency's report shall be approved by the Executive Director and made readily available to the public through its website. 6. TOH will redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility but must indicate the nature of material redacted". Documentation Reviewed 2021 PREA Data Report Interviews: Agency Head – The interviewed staff reported that to date there have been no accusations of sexual harassment or abuse at The Open Hearth. If there are such reports in the future, we will use the data to inform or decisions regarding corrective actions and future plans. PREA Coordinator – The interviewed staff reported that the agency reviews data collected and aggregated pursuant to 115.287. The Administrative staff reviews the data to make informed decisions concerning agency policies and procedures. The data is electronically stored on it's network servers as well as in the Microsoft "cloud". To date there have been no allegations of sexual harassment or abuse to respond to. The agency does prepare an annual report and places it on it's web site. To date there have been no allegations of sexual harassment or abuse to develop corrective actions in response to. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.288 (b). As reported in the PAQ, the annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report does not provide an assessment of the agency's progress in addressing sexual abuse.

Documentation Reviewed

2021 PREA Data Report

Interviews

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.288 (c). As reported in the PAQ, the agency makes its annual report readily available to the public at least through its website. The annual reports are approved by the agency head.

Policy: Data Review for Corrective Action policy states that "The agency's report shall be approved by the Executive Director and made readily available to the public through its website".

Documentation Reviewed

Website: CT PREA Statement – The Open Hearth

2021 PREA Data Report

Interviews

Agency Head – The interviewed staff reported that they approve the annual reports.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

115.288. (d). As reported in the PAQ, when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility.

Policy: The Data Review for Corrective Action policy states that "TOH will redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility but must indicate the nature of material redacted".

Documentation Reviewed

Website: CT PREA Statement – The Open Hearth

Interviews:

PREA Coordinator- To date there have been no allegations of sexual harassment or abuse at TOH. Thus. There has been no material requiring redaction. In the event that a report becomes appropriate information that would pose a threat to the security and safety of the program would be redacted as well as any information that compromises the confidentiality of residents.

Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.:

Corrective Action and Conclusion:

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.289	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Data Storage, Publication, and Destruction Website: CT PREA Statement – The Open Hearth 2021 PREA Data Report Interviews: PREA Coordinator Findings (By Provision): 115.289 (a). As reported in the PAQ, the agency ensures that incident-based and aggregate data are securely retained. The agency indicates the nature of material redacted. Policy: The Data Storage, Publication, and Destruction policy states that "TOH will ensure that data collected pursuant to 115.287 are securely retained". Documentation Reviewed Website: CT PREA Statement – The Open Hearth 2021 PREA Data Report Interviews PREA Coordinator – The interviewed staff reported that the agency reviews data collected and aggregated pursuant to 115.287. The Administrative staff reviews the data to make informed decisions concerning agency policies and procedures. The data is electronically stored on its network servers as well as in the Microsoft "cloud". To date there have been no allegations of sexual harassment or abuse to respond to. The agency does prepare an annual report and places it on it's web site. To date there have been no allegations of sexual harassment or abuse to develop corrective actions in response to. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.: 115.289 (b). As reported in the PAQ, the agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public at least annually through its website. Policy: The Data Storage, Publication, and Destruction policy states that ". TOH shall make all aggregated sexual abuse data readily available to the public at least annually through its website". Recommendation: The auditor reminded the facility to post the PREA audit on its website. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.289 (c). As reported in the PAQ, before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. Policy: The Data Storage, Publication, and Destruction policy states that "Before making aggregated sexual abuse data publicly available, the agency will remove all personal identifiers". Documentation Reviewed 2021 PREA Data Report

	Recommendation: The auditor reminded the facility to post the PREA audit on its website. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.289 (d). As reported in the PAQ, the agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. Policy: The Data Storage, Publication, and Destruction policy states that “TOH will maintain this sexual abuse data collect pursuant to 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise”. Documentation Reviewed: Website: CT PREA Statement – The Open Hearth 2021 PREA Data Report Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Corrective Action and Conclusion: Recommendation: The auditor reminded the facility to post the PREA audit on its website. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the standard. No corrective action is warranted.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents CDOC Contract Findings (By Provision): 115.401 (a). The audited facility serves as a contracted site for the state Department of Corrections agency. As a requirement of their contract, the audited facility has met the obligations of being audited every three years. 115.401 (b). As reported by the PREA coordinator, the agency has insured its sites are audited by the PREA standards. 115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the facility by the director. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred or deterred entry to any areas. The auditor had the ability to freely observe, with entry provided to all areas without prohibition. Based on review of documentation the facility is compliant with the intent of the provision. 115.401 (i). During the on-site visit, the auditor was provided access to any and all documents requested. All documents requested were received to include, but not limited to employee and resident files, sensitive documents, and supplemental reports. Based on review of documentation the facility is compliant with the intent of the provision. 115.401 (m). The auditor was provided a private room to conduct interviews. The staff staged the residents in a fashion that the auditor did not have to wait between interviews. The rooms provided for resident interviews were soundproof and somewhat visually confidential from other residents which was judged to have provided an environment in which the offenders felt comfortable to openly share PREA-related content during interview. It should also be noted that additional precautionary measures were taken to ensure proper social distancing due to the COVID-19. A review of the appropriate documentation and interviews with staff indicate that the facility is in compliance with the provisions of this standard. 115.401 (n). Residents were able to submit confidential information via written letters to the auditor PO Box or during the interviews with the auditor. The auditor did not receive any correspondence from the residents of the facility. Corrective Action and Conclusion: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this standard.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: Website: CT PREA Statement – The Open Hearth Findings (By Provision): 115.403 (f). The audited facility serves as a contracted site for the state Department of Corrections. As a requirement of their contract, the audited facility has met the obligations of being audited every three years. Corrective Action and Conclusion: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this standard.

Appendix: Provision Findings		
115.211 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.211 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities?	yes
115.212 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities, including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.212 (b)	**Contracting with other entities for the confinement of residents**	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.212 (c)	**Contracting with other entities for the confinement of residents**	
	If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
	In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
115.213 (a)	**Supervision and monitoring**	
	Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes

115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	na
115.213 (c)	**Supervision and monitoring**	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?	yes
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female inmates.)	na
	Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female inmates.)	na
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches of female residents?	yes
115.215 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?	yes

115.215 (e)	Limits to cross-gender viewing and searches	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?	yes
	If the resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.215 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes

115.216 (a)	Residents with disabilities and residents who are limited English proficient	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.216 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes

115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?	yes
115.217 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes
115.217 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes

115.217 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.217 (h)	**Hiring and promotion decisions**	
	Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.218 (a)	**Upgrades to facilities and technology**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012 or since the last PREA audit, whichever is later.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	yes
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	na
115.221 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	na
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	na

115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.221 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)	yes
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	na
115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.222 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.222 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).)	yes
115.231 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
115.231 (b)	**Employee training**	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes

115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes
115.232 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.233 (a)	**Resident education**	
	During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes

115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.234 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	na
115.234 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	na
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	na
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	na
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	na
115.234 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a).)	na

115.235 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
	Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes

115.241 (d)	Screening for risk of victimization and abusiveness	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?	yes
115.241 (e)	**Screening for risk of victimization and abusiveness**	
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?	yes
115.241 (f)	**Screening for risk of victimization and abusiveness**	
	Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?	yes
115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident's risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness?	yes

115.241 (h)	**Screening for risk of victimization and abusiveness**	
	Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?	yes
115.241 (i)	**Screening for risk of victimization and abusiveness**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	yes
115.242 (a)	**Use of screening information**	
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?	yes
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes
115.242 (c)	**Use of screening information**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?	yes
115.242 (d)	**Use of screening information**	
	Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes

115.242 (f)	**Use of screening information**	
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
115.251 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.251 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes

115.252 (a)	Exhaustion of administrative remedies	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes
115.252 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	na
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	na
115.252 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: a resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
	Does the agency ensure that: such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
115.252 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	na
	If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension is 70 days per 115.252(d)(3)), does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	na
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	na
115.252 (e)	**Exhaustion of administrative remedies**	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	na
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	na
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	na

115.252 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	na
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
115.252 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	na
115.253 (a)	**Resident access to outside confidential support services**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes
115.253 (b)	**Resident access to outside confidential support services**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.253 (c)	**Resident access to outside confidential support services**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes

115.261 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.261 (b)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.261 (c)	**Staff and agency reporting duties**	
	Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?	yes
	Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.261 (d)	**Staff and agency reporting duties**	
	If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?	yes
115.261 (e)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?	yes
115.262 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.263 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes

115.264 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.264 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.265 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes
115.266 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes
115.267 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?	yes

115.267 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency:4. Monitor resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignment of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.267 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.267 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.271 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	na
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	na
115.271 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?	yes

115.271 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.271 (d)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.271 (e)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.271 (g)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.271 (h)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.271 (i)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?	yes
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes
115.272 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes

115.273 (a)	**Reporting to residents**	
	Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.273 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes
115.273 (c)	**Reporting to residents**	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.273 (d)	**Reporting to residents**	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes
115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes

115.276 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.276 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.277 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.277 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes
115.278 (a)	**Disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process?	yes
115.278 (b)	**Disciplinary sanctions for residents**	
	Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
115.278 (c)	**Disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.278 (d)	**Disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits?	yes
115.278 (e)	**Disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes

115.278 (f)	**Disciplinary sanctions for residents**	
	For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.278 (g)	**Disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.282 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.282 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?	yes
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.282 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na

115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.286 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.286 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes

115.287 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287 (c)	**Data collection**	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.287 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.287 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.287 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	na
115.288 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.288 (b)	**Data review for corrective action**	
	Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?	yes
115.288 (c)	**Data review for corrective action**	
	Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.288 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes

115.289 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	no
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes