PREA Facility Audit Report: Final

Name of Facility: Fellowship House
Facility Type: Community Confinement
Date Interim Report Submitted: NA
Date Final Report Submitted: 06/02/2025

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:** 06/02/2025

AUDITOR INFORMATION	
Auditor name:	Davis, Latera
Email:	laterad@yahoo.com
Start Date of On-Site Audit:	04/07/2025
End Date of On-Site Audit:	04/08/2025

FACILITY INFORMATION	
Facility name:	Fellowship House
Facility physical address:	466 Long Hill Road , Groton , Connecticut - 06340
Facility mailing address:	466 Long Hill Road, Groton,

Primary Contact

Name:	Theresa Main
Email Address:	TMAIN@FHMSERVICES.ORG
Telephone Number:	8604483400

Facility Director	
Name:	David Stevenson
Email Address:	dstevenson@fhmservices.org
Telephone Number:	8604483400

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

Facility Characteristics	
Designed facility capacity:	18
Current population of facility:	16
Average daily population for the past 12 months:	18
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Men/boys
In the past 12 months, which population(s) has the facility held? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For	

definitions of “intersex” and “transgender,” please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	18 - 99
Facility security levels/resident custody levels:	1
Number of staff currently employed at the facility who may have contact with residents:	14
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	3
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	FHM Services, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	466 Long Hill Road , Groton , Connecticut - 06340
Mailing Address:	
Telephone number:	

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

Agency-Wide PREA Coordinator Information

Name:	Theresa Main	**Email Address:**	tmain@fhmservices.org

Facility AUDIT FINDINGS

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:	2025-04-07
2. End date of the onsite portion of the audit:	2025-04-08

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:	Just Detention Connecticut Alliance to End Sexual Abuse

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	18
15. Average daily population for the past 12 months:	18
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	
18. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	17
19. 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
20. 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:	0
21. 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
22. 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
23. 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:	1
24. 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

25. 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
26. 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
27. 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
28. 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
29. 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):	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all residents in the facility. The facility houses all male residents. The facility was able to utilize data from the risk assessment to identity any targeted populations.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
30. 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:	14
31. 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

32. 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
33. 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:	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all staff by title and shift.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

34. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	9
35. 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

36. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	As an auditor, the process of selecting residents for interviews is designed to ensure a fair and unbiased representation of the population. We use a random selection method, often through a random number generator or a similar unbiased tool, to choose residents from the list. This process helps us gather a diverse range of perspectives and ensures that no particular group is either favored or overlooked. Our goal is to obtain an accurate and comprehensive understanding of the environment and conditions from various residents' viewpoints.
37. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	(●) Yes ( ) No
38. 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):	As an auditor, the process of selecting residents for interviews is designed to ensure a fair and unbiased representation of the population. Typically, we use a random selection method, often through a random number generator or a similar unbiased tool, to choose residents from the list. However, due to the limited number of residents at the facility that were onsite during the audit, the auditor selected all those available while onsite.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	1

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".

40. 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
41. 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:	0
41. 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.

41. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

42. 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
42. 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.

42. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
43. 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

43. 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.

43. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

44. 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
44. 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.

44. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

45. 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
45. 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.

45. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

46. 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
46. 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.

46. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
47. 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

47. 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.

47. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

48. 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
48. 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.

48. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

49. 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
49. 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.

49. 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 an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings. The facility does not utilize isolation.

50. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
51. Enter the total number of RANDOM STAFF who were interviewed:	7

52. 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
53. Were you able to conduct the minimum number of RANDOM STAFF interviews?	○ Yes ◉ No
53. Select the reason(s) why you were unable to conduct the minimum number of RANDOM STAFF interviews: (select all that apply)	☐ Too many staff declined to participate in interviews. ☑ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☑ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other
54. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	All staff who were working during the site review was 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.	
55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	13
56. Were you able to interview the Agency Head?	(●) Yes ( ) No
57. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
58. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
59. 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)

60. 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
61. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
62. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
63. Provide any additional comments regarding selecting or interviewing specialized staff.	The site does not have volunteers or contractors.

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.

64. Did you have access to all areas of the facility?	◉ Yes ○ No
Was the site review an active, inquiring process that included the following:	
65. 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

66. 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
67. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
68. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No

69. 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 site review, comprehensive access was granted to all areas of the facility, allowing for a thorough examination of the environment and operations. Key observations included the following: Facility Access: Unrestricted access to various sections of the facility was provided, facilitating a detailed assessment of living conditions, security measures, and common areas. Operational Observations: Several critical functions were tested and observed, including emergency response protocols, security checks, and daily operational routines. These tests demonstrated the facility's preparedness and adherence to established standards. Interactions and Informal Conversations: Informal conversations with staff, residents, and detainees provided additional insights into the daily operations and the overall atmosphere of the facility. These interactions were valuable in corroborating data obtained from documentation and formal interviews. General Observations: The site review highlighted both strengths and areas for improvement within the facility. Observations on cleanliness, maintenance, and the behavior of staff and residents contributed to a comprehensive understanding of the facility's current state.

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.

70. 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

71. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	During the audit process, I took several steps to ensure that the documentation reviewed was thorough and representative of the facility's operations: Oversampling Documentation: In certain instances, I oversampled documentation to gain a deeper understanding of specific areas. For example, I reviewed an increased number of training records and unannounced rounds to identify any recurring patterns or issues that might not be evident from a smaller sample size. Barriers to Selecting Additional Documentation: While the facility provided comprehensive access to most documents, there were some challenges encountered: Time Constraints: The limited time available for the audit sometimes posed a challenge in reviewing all the desired documentation in detail. Document Availability: In a few cases, some documents were not immediately available, however provided by the final audit report. Mitigation Strategies: To address these barriers, I implemented several strategies: Prioritization: I prioritized reviewing documents that were most critical to the audit's objectives and sought summaries or overviews where full documents were not accessible. Supplementary Interviews: When documentation was not fully available, I supplemented the review with additional interviews and discussions with staff and residents to fill in the gaps. Request for Additional Information: I requested additional information or clarifications as needed to ensure that the audit findings were accurate and comprehensive. These steps were taken to ensure a thorough and balanced review of the facility’s documentation, ultimately contributing to a more accurate assessment.

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.

72. 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

73. 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.

74. 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

75. 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.

76. 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

77. 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

78. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	0
78. Explain why you were unable to review any sexual abuse investigation files:	No allegations sexual abuse or sexual harassment were reported or identified.

79. 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	
80. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
81. 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)
82. 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	
83. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
84. 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)

85. 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	
86. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
86. Explain why you were unable to review any sexual harassment investigation files:	No allegations sexual abuse or sexual harassment were reported or identified.
87. 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	
88. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
89. 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)

90. 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	
91. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
92. 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)
93. 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)
94. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	No allegations sexual abuse or sexual harassment were reported or identified.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

95. 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

96. 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

97. 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
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Documentation: Pre-Audit Questionnaire Policy: Zero Tolerance PREA Policy for FHM Services Agency Organization Chart (Flow Chart) Interviews: Agency PREA Coordinator

	Compliance Determination by Provisions and Corrective Actions: 115.211 (a). An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. The PREA Policy serves as the written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policy outlines the agencies' approach to preventing, detecting, and responding. Corrective Actions: N/A. There are no corrective actions for this provision. 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). An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all its facilities. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. Agency Organization Chart: As reported on the organization chart, the agency PREA Coordinator title is Program Director. The position of the PREA Coordinator directly reports to the agency Executive Director. Interviews:

	PREA Coordinator: The staff interviewed reported that they have enough time to manage their PREA-related responsibilities. It was further reported that as the PREA Coordinator, I oversee the agency's PREA response and am the agency's main point of contact for PREA. My efforts include, but are not limited to taking PREA reports, monitoring and updating PREA policies and written materials, providing PREA training and guidance, managing administrative investigations, answering questions about PREA and the agencies response. N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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) CT DOC Contract Findings (By Provision): 115.212 (a). A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency has entered or renewed any contract for the

	confinement of residents. Upon review, the agency/facility does not contract with another entity for the confinement of its 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: 0. The number of above contracts that DID NOT require contractors to adopt and comply with PREA standards: 0. CT DOC Contract: The agency serves as a contracted provider for the Department of Corrections (State of Connecticut Purchase of Service Contract). Corrective Actions: N/A. There are no corrective actions for this provision. 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). Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency policy does require the agency to monitor contracts if they have them. 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. Upon review, the agency/facility does not contract with another entity for the confinement of its 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. 115.212(c). Only in emergency circumstances in which all reasonable attempts to find a private agency or other entity in compliance with the PREA standards have failed, may the agency enter into a contract with an entity that fails to comply with these standards. In such a case, the public agency shall document its unsuccessful attempts to find an entity in compliance with the standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: As reported in the PAQ, the agency has not entered or renewed any contract for the confinement of residents. The facility has not had any emergency circumstances in which all reasonable

	attempts to find a private agency or other entity in compliance with the PREA standards have failed because the facility does not contract with other entities to house their residents. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: The PREA Policy for FHM Services Policy: The Supervision and Monitoring Staff Staffing Plan General Staffing Plan Review (2023/2024) Interviews: Director or Designee PREA Coordinator Findings (By Provision): 115.213(a). For each facility, the agency shall develop and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video

	monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, agencies shall take into consideration: (1) The physical layout of each facility; (2) The composition of the resident population; (3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (4) Any other relevant factors. Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: As reported in the PAQ, the agency requires each facility it operates to develop, document and make its best efforts to comply on a regular basis with a staffing plan. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents: 18. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents on which the staffing plan was predicated: 18. Policy: The PREA Policy for FHM Services states that “The facility shall develop a staffing plan to provide adequate staffing levels and where applicable, video monitoring to ensure staff and resident safety and to protect residents against sexual abuse. When developing the staffing plan, the facility shall take into account the layout, composition of the resident population, and any other relevant factors. Anytime the staffing plan is deviated from, the facility shall document the deviation and justify the reason. Whenever necessary, but at least once a year, the PREA Coordinator shall, in conjunction with the Program Directors assess, determine and document whether adjustments are needed to the staffing plan, video and other monitoring technology, and the resources the facility has available to adhere to the staffing plan (pp. 1-2). Staffing Plan (2022): provides documentation of the agency staffing plan. The staffing plan minimum requirements are determined by the funder, CT Department of Corrections. The number of residents in the program determines the minimum number of staff that should always remain on the floor. The minimum staff requirements can never be deviated from so the staff will always ensure that the minimum staffing is present on the floor. The facility has video monitoring in blind spots throughout the facility and continues to add cameras as money becomes available. Staff complete hourly headcounts/rounds as an additional means of supervision. The Staffing Matrices are established by the funding source however the funding source is open to suggestions based on the agency’s on-going assessments of their needs. The staffing matrix is submitted every year. If the agency/facility has changes to recommend, the funding agency does consider the justifications for the requests. The facility provided a comprehensive layout of the entire premises and the location of residents.

	Site Review: During my site visit, the auditor observed that staff were present and actively monitoring all housing areas throughout the day. The day shift was particularly well-staffed, with additional administrative staff visible and accessible. Staff consistently conducted rounds in both housing and common areas to verify the location of residents. It was noted that the facility does not conduct onsite programming or education. The facility employs 24/7 video monitoring via a comprehensive camera system which covers all internal and external areas except bedrooms and bathrooms, ensuring privacy. However, the cameras allow staff to monitor who enters and exits these private areas. Hourly room checks were diligently performed and documented by staff. Informal conversations with both staff and residents reinforced the observation that staff presence was consistent, and rounds were regularly conducted to ensure resident safety and compliance with PREA standards. Interviews PREA Coordinator: The staff interviewed reported that Staffing plans are assessed for resident sexual safety at least annually and reviewed by the Director. Each plan considers and specifies the physical layout of the facility, the resident population, prevalence of incidents and other factors that impact client safety and monitoring. Findings from any incident reviews are incorporated into the plan with respect to addressing factors that may contribute to PREA incidents including accounting for staff's ability to appropriately monitor residents throughout the facility. Director – The interviewed staff reported that the facility has a documented staffing plan. The plan includes staffing numbers as well as video monitoring. We look at all areas to ensure there are no blind spot, review the logs ins, and the camera system can be always reviewed, as access is available via the Directors phone. The plan is based on DOC requirements. Corrective Actions: N/A. There are no corrective actions for this provision. 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. 115.213(b). In circumstances where the staffing plan is not complied with, the facility documents and justifies all deviations from the plan. Compliance Determination: The facility has demonstrated compliance with this provision of the standards

	because: As reported in the PAQ, there were no deviations in the staffing plan. Policy: The PREA Policy for FHM Services states that “Anytime the staffing plan is deviated from, the facility shall document the deviation and justify the reason. Whenever necessary, but at least once a year, the PREA Coordinator shall, in conjunction with the Program Directors assess, determine and document whether adjustments are needed to the staffing plan, video and other monitoring technology, and the resources the facility has available to adhere to the staffing plan (pp. 1-2). The facility staffing plan is based on the contract with CT DOC. In circumstances where the staffing plan is not complied with, the facility document and notified CT DOC of deviations. Staffing Plan and Staffing Plan Assessment (2024 and 2025): provides documentation of the agency staffing plan and annual assessment that was completed. Interviews Director or Designee – The interviewed staff reported that the facility documents all instances of noncompliance with the staffing plan. Corrective Actions: N/A. There are no corrective actions for this provision. 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. 115.213(c). Whenever necessary, but no less frequently than once each year, the facility shall assess, determine, and document whether adjustments are needed to: (1) The staffing plan established pursuant to paragraph (a) of this section; (2) Prevailing staffing patterns; (3) The facility’s deployment of video monitoring systems and other monitoring technologies; and (4) The resources the facility has available to commit to ensure adequate staffing levels. Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: As reported in the PAQ, at least once every year the facility, reviews the staffing plan to see whether adjustments are needed in (1) the staffing plan, (2) prevailing staffing patterns, (3) the deployment of video monitoring systems and other monitoring technologies, or (4) the allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan.

	Camera: Camera review of location throughout the facility was provided to show the deployment of video monitoring. Staffing Plan and Staffing Plan Assessment (2024 and 2025): provides documentation of the agency staffing plan and annual assessment that was completed. The staffing plan is objective with the number and placement of staff and some video technology that is necessary to ensure the sexual safety of the resident population given the facility layout and characteristics, classifications of residents, and security needs and programming. The agency/facility makes its best efforts to comply on a regular basis with the staffing plan and the facility document deviations from the staffing plan. The agency PREA coordinator is a part of the annual review. Interviews PREA Coordinator – The interviewed staff reported that all staffing plan updates are made in consultation with the PREA Coordinator and reviewed at least once per year. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services PREA Training Curriculum Corrective Action: Training (Cross Gender and Transgender Pat Search) (10) Interviews: Resident Interview Questionnaire (10) Random Sample of Staff (7) Compliance Determination by Provisions and Corrective Actions: 115.215 (a). The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. 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 The facility does not conduct strip searches or body cavity searches at all. Staff are prohibited from conducting any form of search that involves “touching” by either gender staff. Residents are afforded the utmost privacy in restroom/shower areas where the restroom has stalls and doors, and the showers have stalls and curtains and the doors to the restroom/shower areas may be closed as well. Staff are respectful of residents’ living areas and their privacy. There have been no strip search or body cavity searches, and these are prohibited, nor have there been any searches involving “touch.” Residents have privacy while changing clothing because of doors on their rooms. Policy requires Residents and staff to be subject to hands-off searches that will be conducted in a manner that avoids force, embarrassment or indignity to the person being searched. It also requires that pat downs, body cavity and strip searches are prohibited regardless of the gender of the staff or Resident, even in exigent circumstances. Policy: The PREA Policy for FHM Services states that “Cross gender strip searches and body cavity searches are prohibited. If exigent circumstances arise and a cross-

	gender strip search must be conducted for safety or security reasons, the incident shall be immediately reported to the PREA Coordinator and documented via incident report. All staff shall be trained to conduct all strip searches in a professional and respectful manner" (p.3). Audit Site Review: The auditor observed the locations where pat down searches were patted. The staff demonstrated a search and indicated that all searches must occur in front of the camera. These searches typically take place near the front entryway. There are no female residents housed at the facility, so there are no cross-gender searches. Female staff generally do not perform pat down searches, and there is always a male staff member on duty. Female staff have been provided wands for conducting searches. It should be noted that the facility does not conduct strip searches. Informal conversations with staff and residents confirmed that female staff do not perform pat down searches, and that the facility does not conduct strip searches. Corrective Actions: N/A. There are no corrective actions for this provision. 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). As of August 20, 2015, or August 20, 2017, for a facility whose rated capacity does not exceed 50 residents, the facility shall not permit cross-gender pat-down searches of female residents, absent exigent circumstances. Facilities shall not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances (facilities have until August 20, 2015, to comply; or August 20, 2017, if their rated capacity does not exceed 50 residents). It further states that the facility does not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision. N/A as the site is an all-male facility. Interviews Random Sample of Staff – There were no female residents at the program. Resident Interview Questionnaire (Female Residents)- There were no female residents at the program.

	Corrective Actions: N/A. There are no corrective actions for this provision. 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 (c). The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches and shall document all cross-gender pat-down searches of female residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A-the facility does not conduct cross-gender strip searches or visual cavity searches. N/A-there are no female residents at the facility. Policy: The PREA Policy for FHM Services states that “Cross gender strip searches and body cavity searches are prohibited. If exigent circumstances arise and a cross-gender strip search must be conducted for safety or security reasons, the incident shall be immediately reported to the PREA Coordinator and documented via incident report. All staff shall be trained to conduct all strip searches in a professional and respectful manner” (p.3). Corrective Actions: N/A. There are no corrective actions for this provision. 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 (d). The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that "All residents shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender. Staff of the opposite gender are required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing" (p. 3). Site Review: During the site review, the auditor observed the facility critical function of cross-gender viewing. The auditor observes areas where residents may be in a state of undress, showers, toilet, and changing of clothing. The areas observed were housing, intake, showers, bathrooms, common areas. During the site review, the auditor observed the facility critical function of cross-gender announcements. The auditor observes staff announcing their present when entering housing unit/living areas of the opposite gender. The phrase most used by staff is "female." Female staff would also knock before entering room. It should be noted that male staff also knocked before entering the room. During the site review, the auditor observed the facility critical function of cross-gender viewing. The auditor viewed the placement and angle of electronic surveillance monitoring in the main control room. The cameras do not show Residents naked, using the showers or toilets on camera monitors. During the site review, the auditor observed the facility critical function of the physical storage area of any information/documentation collected and maintained as hard copy. The hard copies of the PREA Screening are kept in the residents' files and maintained in lock file cabinet and rooms. There was no confidential resident information located in places where other residents or staff can review. Interviews Resident Interview Questionnaire – The interviewed residents reported that female staff announce their presence when entering the housing area. The residents also reported that the staff will knock on the door prior to making the announcement. All of the interviewed residents reported that they are never naked in full view of opposite gender staff. Random Sample of Staff – The interviewed staff reported that opposite gender staff announce themselves when entering the housing area. It was further reported that residents are able to dress, shower, and use the toilet without being viewed by staff

	of the opposite gender. Several staff reported that they will obtain permission first before entering the rooms. Correction Actions: N/A. There are no corrective actions for this provision. 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). The facility 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 genital status is unknown, it may be determined 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “the facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining genital status” (p. 3). Interviews Random Sample of Staff – The interviewed staff reported that they are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident’s genital status. Transgender/Intersex Residents – There were no transgender or intersex residents onsite during the onsite portion of the audit. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a

	professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. Policy: The PREA Policy for FHM Services states that “Cross gender strip searches and body cavity searches are prohibited. If exigent circumstances arise and a cross-gender strip search must be conducted for safety or security reasons, the incident shall be immediately reported to the PREA Coordinator and documented via incident report. All staff shall be trained to conduct all strip searches in a professional and respectful manner” (p.3). The agency/facility provided the auditor copies of staff training power points that include slides on conducting cross-gender pat down searches, and searches of transgender and intersex Residents in a respectful manner. Training Curriculum: The agency uses the training curriculum created by the Moss Group and available on the PREA Resource Center. Cross-Gender Pat-Down Search Documentation Report provides a mechanism to document said searches. PREA Searches Training Acknowledgement Roster (2/6/2025): 12 staff participated in annual Pat Search Training. Based on the PREA Searches Training Acknowledgement Roster dated February 6, 2025, the facility has demonstrated compliance with Standard 115.215(f). A total of 12 staff members participated in the annual Pat Search Training, which includes instruction on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional, respectful manner, consistent with security needs. This training ensures that staff are equipped to conduct these searches in the least intrusive manner possible, aligning with facility policies and the PREA guidelines. Interviews Random Sample of Staff – All of the interviewed staff reported that they have received training on how to conduct cross gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner. When probed, two staff could not recall the details regarding searching a transgender resident. Corrective Actions: Training (Cross Gender and Transgender Pat Search) (10). The auditor recommended

	additional training for staff on conducting searches of transgender residents. Ø The additional training was completed. No further action is required. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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) PREA Interpreter Information Card (www.jud.ct.gov) Break the Silence Posters (English/Spanish) Interviews: Agency Head Residents (with disabilities or who are limited English proficient) (1) Random Sample of Staff (7) Findings (By Provision): 115.216 (a). The agency 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 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. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans with Disabilities Act, 28 CFR 35.164. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that All residents of the FHM residential programs will have every opportunity to participate in all aspects of sexual abuse, sexual harassment prevention, detection, and response. Interpretation services will be provided as needed. Resident interpreters will not be utilized for any investigation aspects of reported sexual abuse or harassment except where an extended delay in obtaining an effective interpreter could compromise resident's safety or performance of first responders or investigation of resident's allegation. Any use of resident interpreters must be documented" (p. 3). Contracts for Interpreter Services: The facility does not have a contract for interpreter services however the agency has access to said services through PREA Interpreter Information Card (www.jud.ct.gov) Break the Silence Posters (English/Spanish): How to report sexual abuse or sexual harassment is available in English and Spanish. Written Material: Staff Training: Staff receive training on collaborating with individuals with disabilities during the PREA training. The auditor reviewed documentation on (12) new hire training records to verify compliance. Site Review: The auditor assessed access to interpretation services. Onsite staff fluent in Spanish serve as interpreters for the most common second language. For other languages, Intake staff use their phones to interpret.

	During informal conversation with the facility director, the facility will add additional services to access for language assistance. There were no services readily available to residents at the time of the site inspection. However, it should be noted that residents have access to their own cellphones. Interviews Agency Head – The interviewed agency head reported that the agency has a partnership with interpreter services. For disabilities we would partner with one of our community providers. Residents (with disabilities or who are limited English proficient) – One resident was interviewed (one cognitive disability). The interviewed resident mentioned difficulty in understanding information. They further noted that staff read the intake documents upon arrival, but the details were not recalled. The resident stated that staff promptly provides assistance when requested. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that All residents of the FHM residential programs will have every opportunity to participate in all aspects of sexual abuse, sexual harassment prevention, detection, and response. Interpretation services will be provided as needed. Resident interpreters will not be utilized for any investigation aspects of reported sexual abuse or harassment except

	where an extended delay in obtaining an effective interpreter could compromise resident's safety or performance of first responders or investigation of resident's allegation. Any use of resident interpreters must be documented" (p. 3). Contracts for Interpreter Services: The facility does not have a contract for interpreter services however the agency has access to said services through PREA Interpreter Information Card (www.jud.ct.gov) Break the Silence Posters (English/Spanish): How to report sexual abuse or sexual harassment is available in English and Spanish. Site Review (same as a). Interviews Residents (with disabilities or who are limited English proficient) – One resident was interviewed (one cognitive disability). The interviewed resident mentioned difficulty in understanding information. They further noted that staff read the intake documents upon arrival, but the details were not recalled. The resident stated that staff promptly provides assistance when requested. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency 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 resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that All residents of the FHM residential programs will have every opportunity to participate in all aspects of sexual abuse, sexual harassment prevention, detection, and response. Interpretation services will be provided as needed. Resident interpreters will not be utilized for any investigation aspects of reported sexual abuse or harassment except where an extended delay in obtaining an effective interpreter could compromise resident's safety or performance of first responders or investigation of resident's allegation. Any use of resident interpreters must be documented” (p. 3). There were no identified or documented circumstances when resident interpreters, readers, and other resident assistants were used. Interviews Random Sample of Staff – All of the interviewed staff reported that they have never seen the agency allow resident to serve as interpreters for each other. Most staff stated that they would access an interpreter if needed. Residents (with disabilities or who are limited English proficient) – One resident was interviewed (one cognitive disability). The interviewed resident mentioned difficulty in understanding information. They further noted that staff read the intake documents upon arrival, but the details were not recalled. The resident stated that staff promptly provides assistance when requested. Corrective Actions: N/A. There are no corrective actions for this provision 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Following analysis, it has been determined that the facility is compliant with the standard.

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: PREA Policy for FHM Services Personnel: · Pre-Employment Questionnaire (19) · Background Checks (New Hire/Current 10) 5-year background checks (12) Reference Checks (2) Interviews: Administrative (Human Resources) Staff Findings (By Provision): 115.217 (a). The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist 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 (as defined in 42 U.S.C. 1997); (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) of this section. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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: · Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution. · 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 · Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2).

	Employee Records: Document Employee Records provide an overview of the background check process and employee file. Policy: The PREA Policy for FHM Services states that “all employees of FHM residential programs shall have a criminal background check completed at the time of employment, prior to any promotion, and at least once every five years thereafter. All new employees will be appropriately screened by administrative staff before starting employment and are required to disclose any previous misconduct of a sexual nature, whether engaging in, or having attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion; or if the employee has been civilly or administratively adjudicated to have engaged in any of this activity” (p. 3). Personnel Files (10). Personnel files were reviewed and verified that criminal record background checks were conducted and questions regarding pat conduct were asked and answered. Corrective Actions: N/A. There are no corrective actions. 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 (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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Policy: The PREA Policy for FHM Services states that “all employees of FHM residential programs shall have a criminal background check completed at the time of employment, prior to any promotion, and at least once every five years thereafter. All new employees will be appropriately screened by administrative staff before starting employment and are required to disclose any previous misconduct of a sexual nature, whether engaging in, or having attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion; or if the employee has been civilly or administratively adjudicated to have engaged in any of this activity” (p. 3). Interviews Administrative (Human Resources)- The staff interviewed reported that the agency conducts prior institutional reference checks. We also assess for promotions.

Corrective Actions:

N/A. There are no corrective actions for this provision.

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 (c). Before hiring new employees, who may have contact with residents, the agency shall: (1) Perform a criminal background records 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 sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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: 6.

Policy: The PREA Policy for FHM Services states that “all employees of FHM residential programs shall have a criminal background check completed at the time of employment, prior to any promotion, and at least once every five years thereafter. All new employees will be appropriately screened by administrative staff before starting employment and are required to disclose any previous misconduct of a sexual nature, whether engaging in, or having attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion; or if the employee has been civilly or administratively adjudicated to have engaged in any of this activity” (p. 3).

Personnel Files (10). Personnel files were reviewed and verified that criminal record background checks were conducted and questions regarding pat conduct were asked and answered.

Interviews

Administration (Human Resources Staff): The staff interviewed reported that the agency conducts background checks on all employees. The agency does not have contractors but would conduct background checks on them if there were contractors. The agency conducts criminal background checks at the state and

	federal level, in addition to conducting motor vehicle checks. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (d). The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency policy does not require 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. There are no contracted staff to review background checks. Interviews Administration (Human Resources Staff): The staff interviewed reported that the agency conducts background checks on all employees. The agency does not have contractors but would conduct background checks on them if there were contractors. The agency conducts criminal background checks at the state and federal level, in addition to conducting motor vehicle checks. Corrective actions: N/A. There are no corrective actions for this provision. 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). The agency shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: As reported in the PAQ, the agency policy requires that 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 PREA Policy for FHM Services states that "all employees of FHM residential programs shall have a criminal background check completed at the time of employment, prior to any promotion, and at least once every five years thereafter. All new employees will be appropriately screened by administrative staff before starting employment and are required to disclose any previous misconduct of a sexual nature, whether engaging in, or having attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion; or if the employee has been civilly or administratively adjudicated to have engaged in any of this activity" (p. 3). 5- year background check (12) Interviews Administrative (Human Resources) Staff – Criminal background and motor vehicle checks are completed by Prospect Check. The agency recently changed to a new vendor as the vendor also does drug screens. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Pre-employment Questionnaire (19) Interviews Administrative (Human Resources) Staff – The interviewed staff reported that the

	agency asks about previous misconduct for all new hires and promotions. This is done on a pre-employment questionnaire. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Material omissions regarding such misconduct, or the provision of materially false information, are grounds for termination. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: 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. The FHM policy provides guidance on the above. Corrective Actions: N/A. There are no corrective actions. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Administrative (Human Resources) Staff – The interviewed staff stated that the agency does disclose sexual abuse or sexual harassment information to other institutional employers about former employees, unless prohibited by law. Corrective Actions: N/A. There are no corrective actions for this provision.

	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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this 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: PREA Policy for FHM Services Camera Locations Invoice (Alarm Protection by Rugh) Interviews: Agency Head Director Findings (By Provision): 115.218 (a). When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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.

Policy: The PREA Policy for FHM Services states that “FHM residential programs will ensure any substantial modification of existing facility will consider the effect of the design or modification in protecting residents from sexual abuse. Any video equipment upgrade will also consider the program's ability to protect residents from sexual abuse” (p. 4).

Interviews

Agency Head – The interviewed agency head reported that when designing or acquiring a new facility, the agency shall consider how such technology may enhance the agencies’ ability to protect residents from sexual abuse. Primarily camera angles and good site line supervision. We have not had any physical structure changes. Offices-having windows on doors. Almost all offices now have windows on doors. Primary CM office also has a camera in the office.

Director or Designee – The interviewed staff reported that there has been substantial expansions or modifications to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later. A bathroom modification occurred in the main building turning a half bathroom into a full bathroom.

Corrective Actions:

N/A. There are no corrective actions for this provision.

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). When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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 provided documentation of the upgrades made to the video monitoring system Alarm Protection by Rugh on June 28, 2024.

The facility provided documentation of camera locations and reported that additional camera was installed in Lead Case Managers office (F-14)

Interviews:

	Agency Head – The interviewed agency head reported that when installing new technology or a video monitoring system, the agency should consider how it may enhance the agencies' ability to protect residents from sexual abuse. Director or Designee – The interviewed staff reported that when installing new cameras or video monitoring technology the agency shall consider whether the enhancements could better protect residents from sexual abuse. We have had several camera updates and lighting outside. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services MOU: The Sexual Assault Crisis Center of Eastern Connecticut, Inc. PREA End Silence Handbook PREA Crisis Programs The Sexual Assault Crisis Center of Eastern Connecticut, Inc. Email Correspondence (MOU) Interviews:

Random Sample of Staff (7)

Findings (By Provision):

115.221 (a). To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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 Department of Corrections, Groton Police Department, or State Police is responsible for conducting criminal investigations. When conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol.

Policy: The PREA Policy for FHM Services has the following evidence protocol:

· Upon notification of any incident of sexual abuse or sexual assault, staff shall secure the scene of the incident, and at a minimum does not allow the alleged victim or alleged abuser to shower, toilet, eat, drink, or change clothes.

· Upon notification, the PREA Coordinator or designee will contact appropriate the appropriate law enforcement agency who will conduct and coordinate the investigation. The PREA Coordinator or designee shall, in conjunction with law enforcement staff, make transportation arrangements for the alleged victim to receive appropriate medical care at a local hospital where SAFE/SANE staff are available.

· Community based victim services will be made available to victims in addition to Department of Correction Medical and Mental Health Services as needed.

· All incidents of sexual abuse or sexual harassment will be investigated. Any incident involving potential criminal behavior will be immediately reported to local law enforcement for criminal investigation. The PREA Coordinator shall ensure any report of sexual abuse or sexual harassment determined to be a non-criminal matter by law enforcement will be investigated at the facility level.

· The PREA coordinator will also ensure the CT Department of Correction (Parole) is notified of any incidents of sexual abuse or sexual harassment. This information shall be made available on the CT DOC website (p. 4).

Correspondence with Connecticut State Police: correspondence with Connecticut

	State Police confirmed that they would conduct the sexual abuse or criminal related 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, do not touch anything, secure the scene, and make sure no one contaminates the evidence. 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, staff had a variety of responses to how and if they could manage evidence. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall 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. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility does not offer residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. 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 Policy: The PREA Policy for FHM Services has the following evidence protocol states that the PREA Coordinator or designee shall, in conjunction with law enforcement staff make transportation arrangements for the alleged victim to receive appropriate medical care at a local hospital where SAFE/ SANE staff are available. MOU: The Sexual Assault Crisis Center of Eastern Connecticut, Inc. Further the facility has a MOU with the center. The MOU provides that the center will provide

	sexual assault crisis hotline posters in English and Spanish, sexual assault crisis counselor to accompany and support the victim throughout the forensic medical exam process and investigatory interviews, and provide emotional support, crisis intervention, information, and referrals, as requested by the victim. Additionally, the center will collaborate for continuity of care. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency makes available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that Community based victim services will be made available to victims in addition to Department of Correction Medical and Mental Health Services as needed” (p. 4). PREA End Silence Handbook: The agency utilizes the End Silence Handbook created by the PREA Resource Center as a guide to providing information to residents. PREA Crisis Programs provides contact information in English and Spanish on Connecticut Alliance to End Sexual Violence. The organization provides sexual assault crisis programs in Connecticut are free and confidential. Services provided are sexual assault victim advocates, 24/7 hotline, short term counseling for individuals, information and referrals to other social and legal services, and

	accompaniment and support in hospitals, police departments and courts. The Sexual Assault Crisis Center of Eastern Connecticut, Inc.: brochure provides a 24-hour hotline, crisis intervention services, counseling, victim advocacy and support, referral for services, and legal and judicial advocacy. MOU: The Sexual Assault Crisis Center of Eastern Connecticut, Inc. Email correspondence concerning the MOU confirms that the MOA remains valid. Interviews PREA Coordinator – The interviewed staff reported that the agency shall attempt to make a victim advocate available from a rape crisis center. Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Policy: The PREA Policy for FHM Services states that Community based victim services will be made available to victims in addition to Department of Correction Medical and Mental Health Services as needed” (p. 4). PREA End Silence Handbook: The agency utilizes the End Silence Handbook created by the PREA Resource Center as a guide to providing information to residents. PREA Crisis Programs provides contact information in English and Spanish on Connecticut Alliance to End Sexual Violence. The organization provides sexual assault crisis programs in Connecticut are free and confidential. Services provided are sexual assault victim advocates, 24/7 hotline, short term counseling for individuals, information and referrals to other social and legal services, and accompaniment and support in hospitals, police departments and courts. The Sexual Assault Crisis Center of Eastern Connecticut, Inc.: brochure provides a

	24-hour hotline, crisis intervention services, counseling, victim advocacy and support, referral for services, and legal and judicial advocacy. MOU: The Sexual Assault Crisis Center of Eastern Connecticut, Inc. Interviews PREA Coordinator – The interviewed staff reported that victims of sexual abuse shall receive timely access to emergency medical treatment and crisis intervention services. The services would be coordinated with the outside provider. Residents who Reported Sexual Abuse – There were no residents on site who reported sexual abuse during the onsite portion of the audit. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Outside law enforcement agreement-Email Correspondence with the Department of Corrections and Connecticut State police confirms the agency agreement to conduct sexual abuse investigations. Corrective Actions: N/A. There are no corrective actions for this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in 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. 115.221 (g). Auditor is not required to audit this provision. 115.221 (h): For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: Responding to Victims of Sexual Abuse PREA Incident Check Sheet Interviews: Agency Head Investigative Staff (DOC) Email with Correspondence with State Police Findings (By Provision): 115.222 (a). The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Compliance Determinations:

	The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “all incidents of sexual abuse or sexual harassment will be investigated. Any incident involving potential criminal behavior will be immediately reported to local law enforcement for criminal investigation. The PREA Coordinator shall ensure any report of sexual abuse or sexual harassment determined to be a non-criminal matter by law enforcement will be investigated at the facility level. The PREA coordinator will also ensure the CT Department of Correction (Parole) is notified of any incidents of sexual abuse or sexual harassment. This information shall be made available on the CT DOC website (p. 4). There were no incidents of sexual abuse or sexual harassment to review. Correspondence with Connecticut State Police: correspondence with Connecticut State Police confirmed that they would conduct the sexual abuse or criminal related investigations. Interviews Agency Head – The interviewed agency head reported that the agency shall ensure that all allegations of sexual abuse or sexual harassment are investigated. The agency has a PREA coordinator and if there is evidence, we will notify the DOC parole officer, and they will turn it over to Connecticut State Police. The state police or DOC will conduct the investigations. All allegations are reported immediately. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall have in place a policy 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. The agency shall publish such policy on its Web site or, if it does not have one, make the policy available through other means. The agency shall document all such referrals.

	Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that "all incidents of sexual abuse or sexual harassment will be investigated. Any incident involving potential criminal behavior will be immediately reported to local law enforcement for criminal investigation. The PREA Coordinator shall ensure any report of sexual abuse or sexual harassment determined to be a non-criminal matter by law enforcement will be investigated at the facility level. The PREA coordinator will also ensure the CT Department of Correction (Parole) is notified of any incidents of sexual abuse or sexual harassment. This information shall be made available on the CT DOC website (p. 4). There were no incidents of sexual abuse or sexual harassment to review. PREA Incident Check Sheet: this form is used to document the process or next steps after a sexual abuse is reported. Interviews Investigative Staff – The interviewed staff stated all allegations of sexual abuse or sexual harassment are referred to the CT State Police for criminal investigations. Administrative investigations are managed by DOC. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard

	because: The agency’s policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations. Auditor is not required to audit this provision. 115.222 (e). Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations. Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Following analysis and upon review of additional documentation the site has met compliance with the standard.

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: The PREA Policy for FHM Services PREA Zero Tolerance Policy Poster (English/Spanish) PREA Training Curriculum

Training Acknowledgement/Training Records (13)

Refresher Training Material

Refresher Training (14)

Corrective Action:

Mandatory Reporter Training (10)

Interviews:

Random Sample of Staff (7)

Findings (By Provision):

115.231 (a). The agency shall train all employees who may have contact with residents on: (1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' rights to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in confinement; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, 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 PREA Policy for FHM Services states that: · During employee orientation and annually, staff shall receive the following PREA training: · The facility's zero tolerance for all forms of sexual abuse and sexual harassment; · How to fulfill their responsibilities in regard to prevention, detection, reporting, and response; · The resident's right to be free from of sexual abuse and sexual harassment; · The resident's and staff member's right to be free from retaliation for reporting sexual abuse and sexual harassment · The dynamics of sexual abuse and sexual harassment in residential settings, · The common reactions of sexual assault or sexual abuse victims; · How to avoid inappropriate relationships with residents; · How to communicate effectively and professionally with all residents, and PREA Zero Tolerance Policy Poster (English/Spanish): posting on the agency policy related to PREA that is provided in the facility. The PREA Training curriculum addresses all of the above except laws related to the mandatory reporting of sexual abuse to authorities. Interviews Random Sample of Staff – All of the interviewed staff reported that they received training on the above-mentioned elements. The staff reported that they received as a new hire and that they received a refresher recently. When probed the staff were able to describe various components of the training such as signs to look out for if someone is being victimized, and some of the common reactions of sexual abuse victims. Corrective Actions: Mandatory Reporter Training (10): The PREA training did not address mandatory reporter training. The auditor recommended that staff complete the training. Ø Training was completed no further action is required.

	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 (b). Such training shall be tailored to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the training is tailored to the gender of the residents at the facility. Policy: The PREA Policy for FHM Services states that FHM only houses male residents and all PREA training is tailored to that gender. Mary Magdalene House only houses female residents and all PREA training is tailored to that gender (p. 5). The auditor reviewed the PREA training curriculum which provided information specific to the male population at the site. · Responding to Corrections-Based Sexual Abuse: A Guide for Community Corrections Professionals.” · PREA Training PPT: General presentation on the PREA standards. · PREA Acknowledgement Signed/Staff PREA Training Understanding (13) Corrective Actions: N/A. There are no corrective actions for this provision. 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). All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall 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. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	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. Refresher: Employee PREA Training Acknowledgment (14) Corrective Actions: N/A. There are no corrective actions for this provision. 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 (d). The agency shall document, through employee signature or electronic verification, that employees understand the training they have received. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification. Policy: The PREA Policy for FHM Services states that states that “Staff shall sign a training document acknowledging that they understand the training” (p. 5). Staff PREA Understanding Acknowledgement Signed (13) Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Memo Findings (By Provision): 115.232 (a). The agency shall ensure 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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: 2. Upon further review it was determined that the site does not have any volunteers or contractors. The only contractors are individuals who come in to do plumbing, etc. as needed. Policy: The PREA Policy for FHM Services states that "All volunteers or contractors who will have unsupervised contact with residents will receive the same training as noted above for employees. All volunteers and contractors shall sign an acknowledgment that they have received PREA training and that they understand the PREA policy. Volunteers or contractors who have not had background checks conducted will not have contact with residents and will be escorted and supervised by a staff member at all times when in resident areas (p. 5). Memo: the facility provided a memo stating that there is no volunteers or contractors. Interviews Volunteer(s) or Contractor(s) who may have Contact with Residents – There were no reported volunteers or contracted staff.

	Corrective Actions: N/A. There are no corrective actions for this provision. 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). 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, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. It was further reported that all volunteers and contracts receive the same training as employees. Policy: The PREA Policy for FHM Services states that “All volunteers or contractors who will have unsupervised contact with residents will receive the same training as noted above for employees. All volunteers and contractors shall sign an acknowledgment that they have received PREA training and that they understand the PREA policy. Volunteers or contractors who have not had background checks conducted will not have contact with residents and will be escorted and supervised by a staff member at all times when in resident areas (p. 5). Memo: the facility provided a memo stating that there is no volunteers or contractors. Interviews: Volunteer(s) or Contractor(s) who may have Contact with Residents – There were no reported volunteers or contracted staff. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall maintain documentation confirming that volunteers

	and contractors understand the training they have received. Compliance Determination The facility has demonstrated compliance with this provision of the standard because: 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. Policy: The PREA Policy for FHM Services states that “All volunteers or contractors who will have unsupervised contact with residents will receive the same training as noted above for employees. All volunteers and contractors shall sign an acknowledgment that they have received PREA training and that they understand the PREA policy. Volunteers or contractors who have not had background checks conducted will not have contact with residents and will be escorted and supervised by a staff member at all times when in resident areas (p. 5). Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services PREA Zero Tolerance Policy Poster (English/Spanish) Intake Records of Residents/Orientation Receipt (25) Intake Records for Transfer Residents (11) PREA End Silence Handbook PREA Crisis Programs The Sexual Assault Crisis Center of Eastern Connecticut, Inc. PREA Break the Silence (English/Spanish) Interpreter Information Card Resident PREA Pamphlet Offender Handbook Corrective Action: Training/Resident Education (victim advocacy and emotional support) Interviews: Intake Staff (1) Resident (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: 61. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Policy: The PREA Policy for FHM Services states that “During intake orientation, all residents will receive a resident handbook, and a facility handout containing information about PREA. All residents shall sign an acknowledgment that they have received the handbook and the PREA handout which contain the following information: The facility's zero tolerance policy regarding sexual abuse and sexual harassment;

	how to report incidents or suspicions of sexual abuse, sexual harassment; their rights to be free from sexual abuse and sexual harassment; their rights to be free from retaliation for reporting such incidents; and agency policy and procedures for responding to such incidents. PREA End Silence Handbook: The agency utilizes the End Silence Handbook created by the PREA Resource Center as a guide to providing information to residents. PREA Crisis Programs provides contact information in English and Spanish on Connecticut Alliance to End Sexual Violence. The organization provides sexual assault crisis programs in Connecticut are free and confidential. Services provided are sexual assault victim advocates, 24/7 hotline, short term counseling for individuals, information and referrals to other social and legal services, and accompaniment and support in hospitals, police departments and courts. The Sexual Assault Crisis Center of Eastern Connecticut, Inc.: brochure provides a 24-hour hotline, crisis intervention services, counseling, victim advocacy and support, referral for services, and legal and judicial advocacy. PREA Break the Silence Posters: Provides information on how to report sexual abuse and assault. The information is for internal and external reporting. (English/Spanish). FHM PREA Brochure: The FHM sexual harassment, sexual misconduct, and sexual assault brochure provides essential information on recognizing, preventing, and addressing these serious issues. It outlines the definitions, examples, and consequences of such behaviors, emphasizing the importance of creating a safe and respectful environment. This brochure includes resources for support and reporting incidents, ensuring that individuals have access to the necessary tools and guidance to manage these situations effectively. The Offender Handbook provides multiple ways to report sexual abuse or sexual harassment. The handbook states that: All staff, contract workers, volunteers and interns are required to keep all reports of sexual abuse confidential, except to report the information to specific Fellowship House staff. If you have been a victim of sexual abuse or sexual harassment, have witnessed sexual abuse or sexual harassment or have knowledge of any incident of sexual abuse or sexual harassment, you should report these incidents by: · Completing a Help Request Form; · Filing a Grievance (there is no time limit for filing a grievance); · Dropping a note in the Program Director’s box; · Telling a Case Manager, Parole Officer, the Executive Director, Program Director, or Staff that you trust. · External to the facility reporting options:

	· Department of Correction PREA Hotline (1-770-743-7783) · Groton Town Police Department (1-860-441-6712) · National Sexual Assault Hotline (1-800-656-HOPE) Site Review: The facility case manager is responsible for conducting the intake for each client assigned to their case caseload. The facility intake counselor will assign the resident to a community case manager and the case manager will serve as the first person involved with the client from the initiation of placement at the facility. This information will be important for interviewing the right staff who are responsible for the intake process. A mock test was done on the how the facility provides the necessary PREA information to all confined persons, regardless of ability and language, including whether: Staff reported and the auditor observed that they will verbally go over the PREA brochure. The PREA information begins on page 4 of the entire intake process. The staff first asked about familiarity to PREA. Then the staff explained what PREA is and provided examples that are listed in the brochure. The staff proceeded to explain their rights and what their rights are if they have or feel like they are being violated. They will then have them watch the PREA video and cover the different ways to make a report. The staff member reported that the resident could tell the AC in their office, speak to the case manager, or notify their parole officer. The staff then proceeded to ask if understood the information provided and if they have any questions. If a resident appears to or expresses that they do not understand they will slow the information down or answer any clarification questions. As the client's case manager, additional follow-up will occur to verify the residents' understanding. If a resident does not speak English there a several Spanish speaking staff onsite, to include the interviewed case manager. If it is a language unfamiliar to the staff, the staff reported that they have been using language services available on their work issued cellphone. INTERPRETATION SERVICES During the site review, no residents were identified as having Limited English Proficiency (LEP). However, the auditor interacted with three staff members who serve as agency interpreters for Spanish-speaking residents. These staff members work on two different shifts. The auditor assessed access to interpretation services. Onsite staff fluent in Spanish serve as interpreters for the most common second language. For other languages, Intake staff use their phones to interpret. During informal conversation with the facility director, the facility will add additional services to access for language assistance.

There were no services readily available to residents at the time of the site inspection. However, it should be noted that residents have access to their own cellphones.

Interviews:

Intake Staff – The interviewed intake staff reported that the PREA screening is conducted on the first day of arrival at the facility. The intake coordinating will complete the PREA education. This is done by going over the PREA brochure and explaining how to make a report and that the information will be confidential. The staff further reported that they will explain the information to the client and if the resident was LEP they would seek staff assistance or call the language line. If the residents had a cognitive or reading disability, they would still explain the information to them and ask them to repeat to determine their understanding.

Resident Interview Questionnaire – All of the interviewed residents reported that when they first arrived at the facility there were given the rules against sexual abuse and sexual harassment. When probed the residents stated that the staff went over paperwork with them, and this occurred within the same day of placement.

Corrective Actions:

N/A. There are no corrective actions for this provision.

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 (b). The agency shall provide refresher information whenever a resident is transferred to a different facility.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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: 1. The number of residents transferred from a different community confinement facility, during the past 12 months, received refresher information: 11.

Policy: The PREA Policy for FHM Services states that “During intake orientation, all residents will receive a resident handbook, and a facility handout containing information about PREA. All residents shall sign an acknowledgment that they have received the handbook and the PREA handout which contain the following information:

· The facility's zero tolerance policy regarding sexual abuse and sexual

	harassment; how to report incidents or suspicions of sexual abuse, sexual harassment; their rights to be free from sexual abuse and sexual harassment; their rights to be free from retaliation for reporting such incidents; and agency policy and procedures for responding to such incidents. Intake Records for Transfer residents (11). The facility has demonstrated compliance with Standard 115.233(b) which mandates that the agency shall provide refresher information whenever a resident is transferred to a different facility. As reported, the facility ensures that residents who are transferred from different community confinement facilities receive this refresher information as referenced in section 115.233(a)-1. Over the past 12 months, the facility has successfully provided refresher information to all 11 residents transferred from other community confinement facilities. N/A. There are no corrective actions for this provision. 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. Interviews Intake Staff – The interviewed staff reported that when residents are transferred from other sites, they will go over the intake packet with them to ensure they understand the information. The information is provided verbally, and residents are provided a packet prior to signing acknowledgement of receipt. Residents are given the PREA education typically on the first day of arrival. Resident Interview Questionnaire – The interviewed residents reported that they arrived at the facility within the last nine months. The residents either arrived from home or at another facility. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that All residents of the FHM residential programs will have every opportunity to participate in all aspects of sexual abuse, sexual harassment prevention, detection, and response. Interpretation services will be provided as needed. Resident interpreters will not be utilized for any investigation aspects of reported sexual abuse or harassment except where an extended delay in obtaining an effective interpreter could compromise resident's safety or performance of first responders or investigation of resident's allegation. Any use of resident interpreters must be documented. The policy further states that “the resident handbook, PREA handout, and all related material will be made available various formats to ensure those residents with limited English proficiencies, deaf, visually impaired, or otherwise disabled residents will be able to participate in all aspects of PREA” (p. 5). PREA End Silence Handbook: The agency utilizes the End Silence Handbook created by the PREA Resource Center as a guide to providing information to residents. PREA Crisis Programs provides contact information in English and Spanish on Connecticut Alliance to End Sexual Violence. The organization provides sexual assault crisis programs in Connecticut are free and confidential. Services provided are sexual assault victim advocates, 24/7 hotline, short term counseling for individuals, information and referrals to other social and legal services, and accompaniment and support in hospitals, police departments and courts. The Sexual Assault Crisis Center of Eastern Connecticut, Inc.: brochure provides a 24-hour hotline, crisis intervention services, counseling, victim advocacy and support, referral for services, and legal and judicial advocacy. PREA Break the Silence Posters: Provides information on how to report sexual abuse and assault. The information is for internal and external reporting. (English/Spanish). Contracts for Interpreter Services: The facility does not have a contract for interpreter services however the agency has access to said services through PREA Interpreter Information Card (www.jud.ct.gov). Resident PREA Pamphlet: The resident PREA Pamphlet provides information on how to report, what to do if you have been sexually assaulted. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency maintains documentation of resident participation in PREA education sessions. FHM PREA Brochure: The FHM sexual harassment, sexual misconduct, and sexual assault brochure provides essential information on recognizing, preventing, and addressing these serious issues. It outlines the definitions, examples, and consequences of such behaviors, emphasizing the importance of creating a safe and respectful environment. This brochure includes resources for support and reporting incidents, ensuring that individuals have access to the necessary tools and guidance to manage these situations effectively. PREA Education Acknowledgement (25): provides written verification of the resident's completion of the PREA education. The education occurred consistently on the first day of intake. 12-month roster of residents: during the pre-audit phase of the audit, the auditor reviewed the 12-month roster and randomly selected residents to conduct a file review. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (e). In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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.

	PREA End Silence Handbook: The agency utilizes the End Silence Handbook created by the PREA Resource Center as a guide to providing information to residents. PREA Crisis Programs provides contact information in English and Spanish on Connecticut Alliance to End Sexual Violence. The organization provides sexual assault crisis programs in Connecticut are free and confidential. Services provided are sexual assault victim advocates, 24/7 hotline, short term counseling for individuals, information and referrals to other social and legal services, and accompaniment and support in hospitals, police departments and courts. The Sexual Assault Crisis Center of Eastern Connecticut, Inc.: brochure provides a 24-hour hotline, crisis intervention services, counseling, victim advocacy and support, referral for services, and legal and judicial advocacy. PREA Break the Silence Posters: Provides information on how to report sexual abuse and assault. The information is for internal and external reporting. (English/Spanish). 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. Information was provided in Spanish and English. Additionally, information was provided in areas in which visitors could access. The auditor actively observed various aspects of signage throughout the facility to ensure that crucial sexual safety information is effectively communicated to both staff and individuals confined in the facility. This involves assessing the readability, accessibility, accuracy, consistency, and placement of signage. 1. Readability and Accessibility: · The Signage language was clear and understandable. · Services- signage clearly outline available services and their purposes. · Signage was provided in English as well as translated into the other languages (Spanish) commonly spoken in the facility. · Text size, formatting, and physical placement accommodated most readers, including those with visual impairments or physical disabilities. 2. Accuracy and Consistency: · Information on signage was accurate and consistent throughout the facility. The auditor assessed the functionality, and the numbers provided. · Audit notices were relevant to the current audit, and contact information was consistent for service providers or organizations. 3. Placement: · Signage was placed in areas accessible to staff and individuals confined in the

	facility. · Key PREA information was continuously and readily available throughout the facility, including in staff dining areas, break rooms, multipurpose rooms, housing areas, etc. In addition to observation, the auditor engaged in informal conversations with both staff and individuals to gather insights regarding signage, including its readability, accessibility, consistency, and whether it is always available or only posted for audits. Several residents articulated that information was provided at intake, but new signage was posted during the audit process. Corrective Actions: Resident Education: The facility must educate residents on how to access victim advocacy and emotional support services, along with detailed descriptions of these services. Documentation confirming that this education has taken place must be provided. Ø Corrective Action Taken: The facility educated the residents on the process of victim advocacy and emotional support. The training material used to educate the residents was the PREA Pamphlet. The auditor observed 17 residents received the additional education. Staff Education: The facility must educate staff members, including intake staff, about victim advocacy and emotional support services. This training must cover detailed information about the services available. Documentation verifying that staff have received this education must be provided. Ø Documentation was provided showing that staff received the additional training. No further action is required. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services DOC NIC Certificate Corrective Action: PREA Coordinator/NIC Training Interviews: Investigative Staff (DOC) Findings (By Provision): 115.234 (a). In addition to the general training provided to all employees pursuant to § 115.231, the agency shall ensure that, to the extent the agency conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency policy does not require that investigators are trained in conducting sexual abuse investigations in confinement settings. The agency has one PREA investigator which is also the agency PREA Coordinator. The agency does not conduct sexual abuse or sexual harassment administrative or criminal investigations. Policy: PREA Policy for FHM Services states that “it is the policy of FHM residential programs that any criminal act is referred and reported to local law enforcement and the CT DOC (Parole) (p. 5). Interviews Investigative Staff – The interviewed staff stated that they have completed the NIC training courses called PREA: Investigating Sexual Abuse in a Confinement Setting and PREA: Coordinators’ Roles and Responsibilities. Corrective Actions: Training: While the DOC conducts the investigations the auditor recommended that an agency staff also complete training as the agency conducts the initial fact-finding components associated with an allegation. Ø The PREA Coordinator completed the NIC training. No further action is required.

	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). Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Policy: PREA Policy for FHM Services states that “t is the policy of FHM residential programs that any criminal act is referred and reported to local law enforcement and the CT DOC (Parole) (p. 5). The agency does not conduct sexual abuse or sexual harassment administrative or criminal investigations. Interviews: Investigative Staff – The interviewed staff stated that the training topics included in the training were: PREA Investigative Standards, Criteria and Evidence for Administrative Action and Prosecution, the Role of Medical and Mental Health in the Investigative Process, Roles of the Victim Advocate, Working with Victims, Proper use of Miranda and Garrity Warnings, Sexual Abuse Evidence Collection in Confinement Settings, Interviewing Techniques, and Institutional Culture and Investigations. Corrective Actions: Training: While the DOC conducts the investigations the auditor recommended that an agency staff also complete training as the agency conducts the initial fact-finding components associated with an allegation. Ø The PREA Coordinator completed the NIC training. No further action is required. 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). The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	As reported in the PAQ, the agency does not maintain documentation showing that investigators have completed the training required. The number of investigators currently employed who have completed the required training: 0. The agency does not conduct sexual abuse or sexual harassment administrative or criminal investigations. Policy: PREA Policy for FHM Services states that “it is the policy of FHM residential programs that any criminal act is referred and reported to local law enforcement and the CT DOC (Parole) (p. 5). Corrective Actions: Training: While the DOC conducts the investigations the auditor recommended that an agency staff also complete training as the agency conducts the initial fact-finding components associated with an allegation. Ø The PREA Coordinator completed the NIC training. No further action is required. 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). Any State entity or Department of Justice component that investigates sexual abuse in confinement settings shall provide such training to its agents and investigators who conduct such investigations. Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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) Policy: PREA Policy for FHM Services

	Findings (By Provision): 115.235 (a). The agency does not ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: (1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A-As reported in the PAQ, the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. 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. Policy: The PREA Policy for FHM Services states that “FHM residential programs do not employ medical staff. All medical and mental health services are referred to Lawrence & Memorial Hospital or the CTDOC” (p. 6). Corrective Actions: N/A. There are no corrective actions for this provision. 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. 115.235 (b). If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A the agency does not have medical staff. 115.235 (c). The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have onsite medical and mental health services. During the onsite portion of the audit, it was determined that the facility has one onsite clinical staff. Corrective Action: N/A. There are no corrective actions for this provision. 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. 115.235 (d). Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.231 or for contractors and volunteers under § 115.232, depending upon the practitioner's status at the agency. Compliance Determination: Corrective Action: N/A. There are no corrective actions for this provision. 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. The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have onsite medical and mental health services. During the onsite portion of the audit, it was determined that the facility has one onsite clinical staff. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Resident Completed Screening (25) Resident Completed Rescreening (23) Corrective Action Documents: Assessments/Reassessments Update: Screening Tool Interviews: Staff Responsible for Risk Screening (1) Resident Interview Questions (10) PREA Coordinator Findings (By Provision): 115.241 (a). All residents shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “all residents shall be assessed upon intake to an FHM residential program. Intake screening shall be conducted immediately upon arrival but no later than 72 hours after arrival” (p. 6). Audit Site Review: During the site review the auditor observed some PREA signage in the main area of the site. The audit encompassed a comprehensive review of the PREA risk screening or mock demonstration process. The following activities were meticulously assessed. · The auditor verified the individuals responsible for conducting the risk

screening, a critical step to ensure targeted interviews with the appropriate staff members. The intake staff directly asked the resident the intake questions.

· Evaluation was conducted to ascertain whether the screening process occurred in an environment conducive to privacy, minimizing the risk of sensitive information exposure. This included ensuring screenings were conducted out of earshot of other staff and confined individuals not involved in the process.

· Screening staff's approach to questioning was analyzed to determine if it fostered a sense of comfort and encouraged open responses from the individuals undergoing screening. The intake staff was patient and rearticulated, if necessary, the questions.

· Additionally, informal conversations were held with both staff and confined individuals during the risk screening process. These conversations provided valuable insights into various aspects of the screening process, including information collection methods, specifics of the screening tool, and the maintenance of privacy. Moreover, feedback was gathered regarding the comfort levels of confined individuals in answering questions during the screening process.

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the risk of sexual victimization or risk of sexual abuse is done at intake. Intake is typically done immediately upon client arrival.

Resident Interview Questionnaire – All of the interviewed residents reported that 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 the residents reported that the questions were asked the same day or within a few days.

Corrective Actions:

Corrective Action Documents:

· Assessments/Reassessments

Upon final review of corrective action documents (assessments and reassessments) the facility is in compliance with the provision.

115.241 (b). Intake screening shall ordinarily take place within 72 hours of arrival at the facility.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

According to the PAQ, the policy requires that residents be screened for risk of

	sexual victimization or risk of sexual abuse of 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: 101. Policy: The PREA Policy for FHM Services states that “all residents shall be assessed upon intake to an FHM residential program. Intake screening shall be conducted immediately upon arrival but no later than 72 hours after arrival” (p. 6). PREA Screening Risk Assessment (25) The auditor reviewed the PREA Screening Risk Assessment verifying that the risk screenings were conducted within 72 hours of the admission. The risk screenings were consistently completed on the same day of arrival to the facility. The auditor compared the risk screening with the placement date. A random set of residents were selected from the auditor to review. Interviews Staff Responsible for Risk Screening – The interviewed staff reported that the risk of sexual victimization or risk of sexual abuse is done at intake. The screening typically takes place on the first day of arrival. Resident Interview Questionnaire – All of the interviewed residents reported that 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 the residents reported that the questions were asked the same day or within a few days. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Such assessments shall be conducted using an objective screening instrument. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility uses a risk assessment which is conducted using an objective screening instrument. · The auditor reviewed the Risk and Vulnerability Assessment, and it was determined that the site is using an objective screening instrument. Objectivity was determined based on the following:

o Standardized Criteria: It uses pre-determined, clear, and measurable criteria for evaluating risk.

o Consistent Application: The instrument is applied uniformly to all individuals being assessed, ensuring that each person is evaluated using the same criteria and process.

o Quantifiable Metrics: There is a numerical scoring system with clearly defined categories to measure risk, reducing reliance on personal judgment.

· PREA Screening Risk Assessment (25).

Corrective Actions:

N/A. There are no corrective actions for this provision.

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

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· PREA Screening Risk Assessment (25).

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the screening assesses the age, build, criminal history (including non-violent sex offenses), whether the resident has any previous incarcerations, their perceived sexual orientation, and perception of vulnerability. It was stated that the staff ask the questions to all of the residents. This is done by going over the screening assessment with each client in addition to review of client paperwork prior to the screening.

Corrective Actions:

Update Screening Tool:

	Ø The screening tool was updated to include all of the above requirements. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · PREA Screening Risk Assessment has a section that addresses any prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse. Interviews Staff Responsible for Risk Screening – The interviewed staff reported that the screening assesses the age, build, criminal history (including non-violent sex offenses), whether the resident has any previous incarcerations, their perceived sexual orientation, and perception of vulnerability. It was stated that the staff ask the questions to all of the residents. This is done by going over the screening assessment with each client in addition to review of client paperwork prior to the screening. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Within a set time period, not to exceed 30 days from the resident's arrival at the facility, the facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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: 56. Policy: The PREA Policy for FHM Services states that “The resident shall be reassessed in 1O business days but no later than 30 days from arrival at the facility. Reassessment shall be noted in the Progress Notes of the resident's file” (p. 6). PREA Risk Screening re-assessment (23). It should be noted that the auditor randomly selected assessments to review. Of the 25 randomly selected assessments, 3 of the residents were removed from the program prior to the 30 days. Interviews Staff Responsible for Risk Screening – The interviewed staff reported that the initial screening occurs immediately upon intake and the residents are reassessed within 30 days. The reassessment is done by the case manager. Resident Interview Questionnaire – A majority of the interviewed residents could not recall whether or not the staff have asked them the screening intake questions again since they have been here. It also should be noted that several residents recently arrived to the facility. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (g). A resident's risk level shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “The residents shall be reassessed in 10 business days but not later than 30 days from arrival at the facility. Reassessment shall be noted in the Progress Notes of the resident’s file” (p. 6). Interviews

	Staff Responsible for Risk Screening -The interviewed staff reported that reassessments occur within 30 days and that the case manager will conduct any other reassessments as deemed necessary. Resident Interview Questionnaire – A majority of the interviewed residents could not recall whether or not the staff have asked them the screening intake questions again since they have been here. It also should be noted that several residents recently arrived to the facility. Corrective Actions: Corrective Action Documents: · Assessments/Reassessments Upon final review of corrective action documents (assessments and reassessments) the facility is in compliance with the provision. 115.241 (h). Residents may not be 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · 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 PREA Policy for FHM Services states that "Residents will not be disciplined for refusing to answer or discuss information requested by the intake form" (p. 6). Interviews Staff Responsible for Risk Screening – The interviewed staff reported that residents are not disciplined for refusing to answer any portions of the assessment tool. Corrective Actions: N/A. There are no corrective actions for this provision. 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

residents’ detriment by staff or other residents.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

Audit Site Review:

The audit encompassed a thorough review of the following activities to ensure compliance with PREA Standards:

· The auditor observed the physical storage area where any hard copy information/documentation collected and maintained pursuant to PREA Standards is stored. This includes documents such as risk screening information, medical records, and sexual abuse allegations. The objective was to determine if the storage area is adequately secure, utilizing methods such as key card access, locks, or other security measures.

· The auditor assessed the electronic safeguards in place for information/ documentation collected and maintained electronically as per PREA Standards, particularly focusing on risk screening information. This involved evaluating how access to the electronic information is secured, such as through password protection, access restriction to certain areas, or role-based security protocols.

· In addition to these assessments, the auditor engaged in informal conversations with staff members to gather information regarding access to secure information. Specifically, discussions centered on the storage and security measures for electronic and hard copy information, including medical and mental health files, sexual abuse, and harassment reports, etc. Key topics included the location, methods, and security protocols for storing information both electronically and in hard copy, as well as details regarding access restrictions and authorization procedures for personnel.

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the assessment reports are held in their electronic file and that the case manager and program director. The files are in a locked office drawer.

PREA Coordinator - The staff interviewed reported that information is accessible only to those tasked with monitoring client safety. This would include the lead case manager, the PREA Coordinator and the Executive Director.

Corrective Actions:

N/A. There are no corrective actions for this provision.

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.

	Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations Following analysis, it has been determined that the facility does not currently meet the required standard. As a result, corrective action will be undertaken to ensure compliance is achieved. The facility submitted additional documentation showing corrective action was implemented. The facility is now 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: PREA Policy for FHM Services Facility Layout Interviews: PREA Coordinator Staff Responsible for Risk Screening (1) Transgender (1) 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: A reported in the PAQ, 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 those residents separate at high risk of being sexually victimized from those at high risk of being sexually abusive. Policy: The PREA Policy for FHM Services states that “the facility shall make individual determinations on a case-by-case basis about how to ensure the safety of all residents and shall utilize the screening information to determine housing, work, education, and programming assignments” (p. 7). The facility provided a comprehensive layout of the entire premises and the location of residents. The auditor reviewed the risk screening for randomly selected residents along with the risk screening for a transgender resident. As reported by the intake staff the information from the screening is used to determine placement in the facility. The facility does not conduct any programming or job assignments at the facility. Interviews PREA Coordinator – The interviewed staff reported that all residents are assessed during the intake and evaluation process for their risk of being sexually abused by other residents or sexually abused towards. After the screening is completed the intake staff will report to me if there is any potential victim or previous victim and we will collectively review housing. Make sure bed is a safe place and there is not an aggressor in that space. Equally if they are an aggressor, we are not putting them with a victim. If there is any reported history of abuse, we will offer counseling services. We have a couple of agencies we work with on counseling services. The intake person is excellent in getting individuals in on appointments. Staff Responsible for Risk Screening – The interviewed staff reported that the information is used to ensure resident safety. For example, I would look to see if there is someone with predatory tendencies in the room and not place someone vulnerable to victimization in that room. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall make individualized determinations about how to ensure the safety of each resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency/facility makes individualized determinations

about how to ensure the safety of each resident.

Policy: The PREA Policy for FHM Services states that “the facility shall make individual determinations on a case-by-case basis about how to ensure the safety of all residents and shall utilize the screening information to determine housing, work, education, and programming assignments” (p. 7).

The facility uses the PREA screening information from standard 115.41 to make individualized determinations for all residents regarding housing, bed work, education, and program assignments. These determinations are made to maintain separation between residents at risk of being sexually victimized and residents likely to commit sexual abuse.

The facility layout diagram shows the various locations in which residents could be placed.

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the information is used to ensure resident safety. For example, I would look to see if there is someone with predatory tendencies in the room and not place someone vulnerable to victimization in that room.

Corrective Actions:

· As the auditor, it has been observed that while the agency utilizes the information it has gathered, the existing risk screening tool does not sufficiently encompass all risk factors necessary to fully meet the requirements of the provision. As part of the corrective action phase, the auditor will evaluate the implementation of an enhanced risk assessment tool and monitor the adoption and utilization of the results derived from this tool.

Corrective Action Documents:

· Assessments/Reassessments

Upon final review of corrective action documents (assessments and reassessments) the facility is in compliance with the provision.

115.242 (c). In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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. Policy: The PREA Policy for FHM Services states that “transgender and intersex residents' own views with respect to his or her safety shall be given serious consideration in housing assignments. Transgender and intersex residents shall be given the opportunity to shower separately from other residents, and shall not be placed in a dedicated unit solely based on their identification status” (p. 7) Interviews PREA Coordinator – The interviewed staff reported that housing and program assignments are made on a case-by-case basis, based on information from the PREA Screening and the client at intake. A variety of housing configurations are available based on need and preference. The agency prioritizes resident health and safety when making placement decisions and utilizes a client-centered approach across all services. Transgender/Intersex Residents – There were no identified transgender or intersex residents during the audit period. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the placement and program assignment of transgender and intersex residents are reassessed every six months to review any threats to safety experienced by the resident. It should be noted that there were no transgender or intersex residents housed at the facility during the audit period. Policy: The PREA Policy for FHM Services states that “transgender and intersex residents' own views with respect to his or her safety shall be given serious consideration in housing assignments. Transgender and intersex residents shall be given the opportunity to shower separately from other residents, and shall not be placed in a dedicated unit solely based on their identification status” (p. 7) Interviews PREA Coordinator – The interviewed staff reported that A transgender or intersex resident’s own view with respect to his or her own safety would be given the highest

	consideration in placement and programming assignments. Staff Responsible for Risk Screening – The interviewed staff reported that a transgender person or intersex residents own views of his or her own safety would be given consideration and re-consider all housing/bed assignments. Transgender/Intersex Residents – There were no identified transgender or intersex residents during the audit period. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Policy: The PREA Policy for FHM Services states that “transgender and intersex residents' own views with respect to his or her safety shall be given serious consideration in housing assignments. Transgender and intersex residents shall be given the opportunity to shower separately from other residents, and shall not be placed in a dedicated unit solely based on their identification status” (p. 7) Audit Site Review: When conducting the onsite inspection there was no indication that the site had separate living units for transgender or intersex residents. However, it should be noted that the transgender resident placed at the facility was given a single room with a single bathroom. Interviews PREA Coordinator – The interviewed staff reported that the facility has a configuration that allows for private showering for a transgender or intersex resident. Staff Responsible for Risk Screening – The interviewed staff reported that a transgender person or intersex residents own views of his or her own safety would be given consideration and re-consider all housing/bed assignments. Transgender/Intersex Residents – There were no identified transgender or intersex residents during the audit period. Corrective Actions:

	N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no identified transgender or intersex residents. Interviews PREA Coordinator – The interviewed staff reported that the agency is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, or wing for lesbian, gay, bisexual, transgender, or intersex residents. The policy fosters an inclusive environment. Transgender/Intersex Residents – There were no identified transgender or intersex residents during the audit period. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Following analysis, it has been determined that the facility does not currently meet the required standard. As a result, corrective action will be undertaken to ensure compliance is achieved. The facility submitted documentation showing the use of the objective risk assessment and reassessment is in compliance with the standard.

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: PREA Policy for FHM Services Offender Handbook FHM PREA Brochure Interviews: Random Sample of Staff (7) Resident Interview Questionnaire (10) Findings (By Provision): 115.251 (a). The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “At intake all residents will be advised of all reporting options available to report sexual abuse, sexual harassment, retaliation, staff neglect, or other violations that may have contributed to an incident through the Resident Handbook and the PREA Handout issued upon arrival” (p. 7). The Offender Handbook provides multiple ways to report sexual abuse or sexual harassment. The handbook states that: All staff, contract workers, volunteers and interns are required to keep all reports of sexual abuse confidential, except to report the information to specific Fellowship House staff.

	If you have been a victim of sexual abuse or sexual harassment, have witnessed sexual abuse or sexual harassment or have knowledge of any incident of sexual abuse or sexual harassment, you should report these incidents by: · Completing a Help Request Form; · Filing a Grievance (there is no time limit for filing a grievance); · Dropping a note in the Program Director's box; · Telling a Case Manager, Parole Officer, the Executive Director, Program Director, or Staff that you trust. · External to the facility reporting options: · Department of Correction PREA Hotline (1-770-743-7783) · Groton Town Police Department (1-860-441-6712) · National Sexual Assault Hotline (1-800-656-HOPE) FHM PREA Brochure: The FHM sexual harassment, sexual misconduct, and sexual assault brochure provides essential information on recognizing, preventing, and addressing these serious issues. It outlines the definitions, examples, and consequences of such behaviors, emphasizing the importance of creating a safe and respectful environment. This brochure includes resources for support and reporting incidents, ensuring that individuals have access to the necessary tools and guidance to manage these situations effectively. Audit Site Review: The audit process involved a detailed review of various activities related to reporting mechanisms, mail processes, and record storage, as outlined below: The auditor conducted a test report submission via the facility's reporting system (phone system/computers) during the site review, ensuring alignment with the process available to residents. It should be noted that residents have access to site phones and their own personal phones. The reception of the test report by the facility was assessed, and evidence of receipt was requested and reviewed. Accessibility and functionality of the electronic reporting devices were evaluated, including their availability, accommodations for different needs, privacy measures, and operational status. Additionally, informal discussions were held with both staff and residents regarding electronic reporting procedures, including access, accommodations, operational status, and anonymity considerations. Informal conversations were conducted with confined individuals to ascertain their

	awareness of the option to make verbal reports and the process for doing so. Discussions with staff members were held to determine their understanding of the procedures for receiving and documenting verbal reports. Accessibility and security of writing instruments for residents were assessed, along with the observation of how mail moves within the facility, including via mail drop boxes or staff. Informal conversations took place with staff involved in mail processes residents regarding the privacy, confidentiality, and accessibility of mail procedures. Residents utilize the postal service mail process. The physical storage area of hard copy documentation, including risk screening information and medical records, was observed to determine its security. During the site review, the auditor observed the facility's signage regarding PREA Audit Notices, which were prominently displayed throughout the premises, ensuring visibility to staff, residents, and visitors alike. These notices were strategically posted in living units, common areas, facility entrances, visitation areas, and staff break areas. The information provided on these notices was presented in both English and Spanish, ensuring accessibility to a diverse audience, and was legible. Furthermore, the auditor noted that the facility's signage regarding access to outside confidential emotional support services was similarly well-distributed, with postings in all areas frequented by residents, including housing/living units. This information was consistently displayed throughout the facility, also presented in English and Spanish, and was easily readable. Additionally, signage regarding reporting procedures for sexual abuse and/or sexual harassment, both internally and externally, was observed in residents' housing/ living units, programming areas, and visitation areas. Again, the information was presented bilingually and was clearly legible. Moreover, during the site review, it was observed that the facility provides residents with access to writing instruments, paper, and forms for reporting purposes. The auditor also evaluated the facility's reporting systems for residents, noting that residents can report incidents of sexual abuse and/or sexual harassment through the internal grievance process, written format, or by using a cell phone. A demonstration was requested from a resident to illustrate the steps involved in reporting via phone, and discussions were held regarding the recipients and handling of reports. Importantly, residents have the option to file a written report anonymously, without disclosing their name or the names of alleged perpetrators. This includes incidents that may have occurred prior to their commitment to the current facility. Lastly, the agency/facility offers multiple internal avenues for residents to privately report instances of sexual abuse, sexual harassment, retaliation, or staff misconduct

	that may have contributed to sexual abuse. Interviews Random Sample of Staff – The interviewed staff reported various methods in which residents can privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, or staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment. The various methods include telling staff, calling the hotline, or writing a grievance. Several staff reported being unaware as to how the residents would report to an outside entity. Resident Interview Questionnaire - 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, notify police, notify the parole officer, complete a grievance, or call the hotline. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall also inform residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Compliance Determination: As reported in the PAQ, the agency shall also inform residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Staff are required to document verbal reports. Policy: The PREA Policy for FHM Services states that “Residents shall also receive information on how to privately report any such information to public or private agency while remaining anonymous. Residents may make anonymous reports by calling posted PREA contact numbers or by calling the FHM Administrative office” (p. 7). The Offender Handbook provides multiple ways to report sexual abuse or sexual harassment. The handbook states that: All staff, contract workers, volunteers and interns are required to keep all reports of sexual abuse confidential, except to report the information to specific Fellowship

House staff.

If you have been a victim of sexual abuse or sexual harassment, have witnessed sexual abuse or sexual harassment or have knowledge of any incident of sexual abuse or sexual harassment, you should report these incidents by:

· Completing a Help Request Form;

· Filing a Grievance (there is no time limit for filing a grievance);

· Dropping a note in the Program Director’s box;

· Telling a Case Manager, Parole Officer, the Executive Director, Program Director, or Staff that you trust.

· External to the facility reporting options:

· Department of Correction PREA Hotline (1-770-743-7783)

· Groton Town Police Department (1-860-441-6712)

· National Sexual Assault Hotline (1-800-656-HOPE)

FHM PREA Brochure: The FHM sexual harassment, sexual misconduct, and sexual assault brochure provides essential information on recognizing, preventing, and addressing these serious issues. It outlines the definitions, examples, and consequences of such behaviors, emphasizing the importance of creating a safe and respectful environment. This brochure includes resources for support and reporting incidents, ensuring that individuals have access to the necessary tools and guidance to manage these situations effectively.

Site Review:

The auditor assessed the readability and accessibility of facility signage, particularly focusing on language clarity, provision of service details, language translation, text size, formatting, and physical placement. Signage throughout the facility was observed to meet these criteria, ensuring clear communication with residents, staff, and visitors. The signage displayed was a 5th grade level.

Specific areas where signage regarding reporting procedures for sexual abuse and/or harassment was located were identified, including housing/living units, programming areas, and common areas.

The auditor assessed the functionality of the facility's phone reporting system by placing test calls to the external reporting entity. This included assessing phone operability, connection to the correct external entity, anonymity options, and the entity's readiness to receive and forward reports. The auditor directly spoke with a DOC investigator and State Trooper to confirm the process of accepting allegations of sexual abuse or sexual harassment.

Accessibility of phones for all residents, including those with disabilities, was

	evaluated. Additionally, mechanisms ensuring anonymous reporting were reviewed, ensuring privacy and confidentiality for residents. It should be noted that individuals had access to their own personal cell phone device. Accessibility of writing instruments and the movement of mail within the facility were observed. Mail drop boxes/receptacles were assessed for accessibility and anonymity, with a focus on ensuring secure and discreet reporting options. The site utilizes the public USPS process however individuals can drop mail at a post office. The security of written communication was evaluated, including the locking/ securing of mail drop boxes/receptacles and restricted access to designated facility officials. Grievance boxes were locked and secured. Additionally, informal conversations were held with staff and residents to gather insights into the process of sending and receiving mail, including external reporting, emotional support services, and legal mail. Discussions covered privacy, confidentiality, anonymity, and accessibility considerations. Individuals knew how to access emotional support services but did not know details as they reported not needing them. Additionally, individuals expressed feeling confident that they could have confidential and accessible services if needed. Interviews PREA Coordinator – The interviewed staff reported that if a client wishes to report abuse or harassment to an entity outside of the agency, they can contact the Sexual Assault Hotline, tell staff, or the police department. The agency provides clients with the Sexual Assault Hotline number at orientation, as well as information about their options for making such reports. The number is also posted in English and Spanish at the facilities. The procedures enable receipt and immediate transmission of resident reports of sexual abuse and sexual harassment to the agency, while the resident may choose to remain anonymous upon request. Resident Interview Questionnaire - The interviewed residents reported that they are aware of multiple methods to report sexual abuse or sexual harassment. The various ways reported include telling staff, notifying police, notifying the parole officer, completing a grievance or call the hotline. All of the interviewed residents reported that they believe they could make a report without having to give their name. Moreso residents were confident in their ability to use their own phones to make a report. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 within 24 hours. Policy: The PREA Policy for FHM Services states that “Residents shall also be notified that any staff member must accept and promptly document any report made verbally, in writing, anonymously, or from a third party. Staff have been informed through ongoing training that IMMEDIATE notification to their supervisor is necessary regarding any information related to PREA. The Supervisor will then ensure that the PREA Coordinator is informed immediately as well” (p. 7). Interviews Random Sample of Staff – The interviewed staff reported that a resident who alleges sexual abuse, can do so verbally, in writing, anonymously and from a third party. When asked do you document the report, all of the staff stated yes. It was further reported that they would document immediately 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. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (d). The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Policy: The PREA Policy for FHM Services states that “Staff members shall be provided a method to privately report sexual abuse or sexual harassment of residents. Staff members may report verbally or in writing to their program manager and/or to the Executive Director” (p. 7). Staff are provided information on the various ways to privately report in their PREA training indicated in standard 115.331.

	Site Review: As part of the audit process, the auditor initiated the review of staff reporting methods by engaging a staff member to demonstrate the procedures provided by the facility. This walkthrough aimed to ascertain the accessibility and functionality of the staff reporting method(s). Observations were made regarding the availability of the staff reporting method(s) to all staff in the facility. The audit focused on determining whether the reporting system is readily accessible to staff members upon request. The staff reported making reports to the director. The director's office is not near resident area therefore confidential conversation could occur. Additionally, the auditor assessed whether staff are mandated to report incidents to their direct colleagues or their immediate supervisor. While it is the preferred method to report to immediate supervisor, staff could articulate other means to make a report. Interviews Random Sample of Staff – The interviewed staff reported that they could privately report sexual abuse and sexual harassment of residents by calling the PREA hotline, call law enforcement, notifying chain of command, or notify the PREA coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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) Policy: PREA Policy for FHM Services Findings (By Provision): 115.252 (a). An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Policy PREA Policy for FHM Services states that “PREA related issues are not subject to the grievance procedure” (p. 7). Corrective Actions: N/A. There are no corrective actions for this provision. 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 (b). (1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. (2) The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse. (3) The agency shall not require a resident to use any informal grievance process, or to attempt to resolve with staff, an alleged incident of sexual abuse. (4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (c). The agency shall ensure that: (1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (d). (1) The agency shall 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. (2) Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal. (3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made. (4) 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, the resident may consider the absence of a response to be a denial at that level. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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). (1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in

	filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. (2) If a third party files such a request on behalf of an 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. (3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (f). (1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision documents the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (g). The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services PREA Brochure (English/Spanish) PREA MOU: Sexual Assault Crisis Center of Eastern Connecticut, Inc

	PREA Crisis Programs Sexual Assault Crisis Center of Eastern Connecticut, Inc FHM PREA Brochure Corrective Action Staff Training Resident Education Interviews: Resident Interview Questionnaire (10) Findings (By Provision): 115.253 (a). The facility shall 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, and by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “Residents are provided contact information to outside victim advocates and support services when requested. FHM residential programs have access to CONNSACS (Connecticut Sexual Assault Crisis Services) through an MOU with the CTDOC. Any resident may call the toll-free CONNSACS number at any time. Additionally, FHM has an executed MOA with Sexual Assault Crisis Center of Eastern Connecticut” (p. 7). PREA Crisis Programs provides contact information in English and Spanish on Connecticut Alliance to End Sexual Violence. The organization provides sexual assault crisis programs in Connecticut are free and confidential. Services provided are sexual assault victim advocates, 24/7 hotline, short term counseling for individuals, information and referrals to other social and legal services, and

	accompaniment and support in hospitals, police departments and courts. The Sexual Assault Crisis Center of Eastern Connecticut, Inc.: brochure provides a 24-hour hotline, crisis intervention services, counseling, victim advocacy and support, referral for services, and legal and judicial advocacy. Further the facility has a MOU with the center. The MOU provides that the center will provide sexual assault crisis hotline posters in English and Spanish, sexual assault crisis counselor to accompany and support the victim throughout the forensic medical exam process and investigatory interviews, and provide emotional support, crisis intervention, information, and referrals, as requested by the victim. Additionally, the center will collaborate for continuity of care. FHM PREA Brochure: The FHM sexual harassment, sexual misconduct, and sexual assault brochure provides essential information on recognizing, preventing, and addressing these serious issues. It outlines the definitions, examples, and consequences of such behaviors, emphasizing the importance of creating a safe and respectful environment. This brochure includes resources for support and reporting incidents, ensuring that individuals have access to the necessary tools and guidance to manage these situations effectively. Site Review: The auditor conducted a test report submission via the facility's reporting system (phone system/computers) during the site review, ensuring alignment with the process available to residents. It should be noted that residents have access to site phones and their own personal phones. The reception of the test report by the facility was assessed, and evidence of receipt was requested and reviewed. The auditor called the numbers on the PREA poster and brochures and assessed the information provided. The auditor called and left a message with the PREA Coordinator, as listed on the brochure, and received an email back receiving confirmation of the call. The auditor called the Department of Corrections and spoke to the investigator confirming the ability that residents can make an allegation of sexual abuse or sexual harassment. The investigator reported that they would notify the facility and conduct the investigation. Accessibility and functionality of the electronic reporting devices were evaluated, including their availability, accommodations for different needs, privacy measures, and operational status. Residents have access to their own cellphones and if they do not have a phone there is a phone available at the facility. Informal conversations were conducted with confined individuals to ascertain their awareness of the option to make verbal reports and the process for doing so. Residents were able to articulate at least one way to make a report. It should also be noted that residents had a heightened awareness of PREA as they all had been transferred from a jail or prison. Residents were also comfortable with being able to say that they could call 911 if needed. Discussions with staff members were held to determine their understanding of the

	procedures for receiving and documenting verbal reports. Staff were proficient in immediately notifying the supervisor or the director. Additionally, staff could readily articulate documenting verbal reports immediately. The auditor observed that on the back of the staff ID was a process listed for how to respond to allegations of sexual abuse or sexual harassment. Accessibility and security of writing instruments for residents were assessed, along with the observation of how mail moves within the facility, including access to grievance forms and a grievance box. However, residents reported just leaving a note in the grievance box. Informal conversations took place with staff involved in mail processes residents regarding the privacy, confidentiality, and accessibility of mail procedures. Residents utilize the postal service mail process. Staff do not open or read mail; however, if a package comes, they must open the package in front of staff. There is a mail slot hosted at the entryway of the facility where incoming and outgoing mail resides. For incoming mail, the mail carrier leaves at the front desk and staff will notify the residents that the mail has arrived. If requested the facility will provide the residents with stamps and envelopes. The physical storage area of hard copy documentation, including risk screening information and medical records, was observed to determine its security. The facility utilizes a paper screening process, and the active records are maintained in a locked cabinet in the assigned case managers office. The inactive files are maintained in a locked room that is only accessible to leadership staff. Records are destroyed after five years. During the site review, the auditor observed the facility's signage regarding PREA Audit Notices, which were prominently displayed throughout the premises, ensuring visibility to staff, residents, and visitors alike. These notices were strategically posted in living units, common areas, facility entrances, and visitation areas. The information provided on these notices was presented in both English and Spanish, ensuring accessibility to a diverse audience, and was legible. The facility requires any visitor to the site to sign information on the PREA Zero Tolerance Rules (uploaded). Furthermore, the auditor noted that the facility's signage regarding access to outside confidential emotional support services was readily available and visible onsite. Additionally, signage regarding reporting procedures for sexual abuse and/or sexual harassment, both internally and externally, was observed in residents' housing/ living units, programming areas, and visitation areas. Again, the information was presented bilingually and was clearly legible. The auditor also evaluated the facility's reporting systems for residents, noting that residents can report incidents of sexual abuse and/or sexual harassment through the internal grievance process, written format, or by using a cell phone. A demonstration was requested from a resident to illustrate the steps involved in

	reporting via phone, and discussions were held regarding the recipients and handling of reports. Importantly, residents have the option to file a written report anonymously, without disclosing their name or the names of alleged perpetrators. This includes incidents that may have occurred prior to their commitment to the current facility. Lastly, the agency/facility offers multiple internal avenues for residents to privately report instances of sexual abuse, sexual harassment, retaliation, or staff misconduct that may have contributed to sexual abuse. Internally to the PREA Coordinator and externally to the Department of Corrections Investigation Unit. Interviews Resident Interview Questionnaire – Three of the ten interviewed residents reported that they were aware of outside services that deal with sexual abuse if needed. Only one of them could name a specific place. The others said in general that they know there are services, just cannot recall which ones and/or stated domestic violence shelters. When asked if the facility provided them with mailing addresses and toll-free telephone numbers, the residents could recall receiving information and that the information was posted. It was further reported that if they wanted to talk to the outside services they could be on their own as they had their own cell phones. The residents felt that they could have a private conversation with the outside services. One resident reported that the outside service would have to report abuse that occurred at the facility. Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process. Corrective Actions: Resident Education: The facility must educate residents on how to access victim advocacy and emotional support services, along with detailed descriptions of these services. Documentation confirming that this education has taken place must be provided. Ø Corrective Action Taken: The facility educated the residents on the process of victim advocacy and emotional support. The training material used to educate the residents was the PREA Pamphlet. The auditor observed 17 residents received the additional education. Staff Education: The facility must educate staff members, including intake staff, about victim advocacy and emotional support services. This training must cover detailed information about the services available. Documentation verifying that staff have received this education must be provided. Ø Documentation was provided showing that staff received the additional training. No further action is required. 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). The facility shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “resident phone calls are not monitored or recorded. All calls are confidential” (p. 7). Residents at the facility have access to their own cell phones and a majority receive services (job/mental health) outside of the facility therefore have the ability to have confidential communication. Interviews Resident Interview Questionnaire – Three of the ten interviewed residents reported that they were aware of outside services that deal with sexual abuse if needed. The residents felt that they could have a private conversation with the outside services. One resident reported that the outside service would have to report abuse that occurred at the facility. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: 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 Sexual Assault Crisis Center of Eastern Connecticut. 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. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Website: Fellowship House Ministries PREA Brochure (English/Spanish)

	Findings (By Provision): 115.254 (a). The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency or facility does not provide 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. · Policy: The PREA Policy for FHM Services states that Any third-party reports of sexual abuse may be made via telephone, fax, email, or in person. FHM Services is a contracted unit of the Connecticut Department of Corrections, and the facility address, telephone and facsimile numbers can be found on their website at: www.ct.gov/doc “(p. 8). · PREA Brochure (English/Spanish): provided to residents at intake provides various methods for reports of allegations of sexual abuse and sexual harassment. · Website Fellowship House Ministries: Provides information to the public on third party reporting. Audit Site Review: During the site review, the auditor meticulously observed facility signage to assess its readability and accessibility. The clarity and comprehensibility of signage language, especially concerning services like emotional support and external reporting, were thoroughly examined. It was ensured that signage was provided in English and translated into other prevalent languages, catering to the diverse linguistic needs of the facility's population. The auditor paid close attention to signage text size, formatting, and physical placement to ensure it accommodated a wide range of readers, including those with visual or physical impairments. Signage was checked and determined to be at the 5th grade reading level. The accuracy and consistency of information across facility signage were carefully evaluated during the site review. This encompassed verifying that audit notices were pertinent to the current audit and confirming the consistency of contact information for service providers/ organizations. The auditor was able to readily access the investigator with the

	Department of Corrections and the Connecticut State Troopers and confirm their response to receiving any reports. There were no instances identified. Additionally, the auditor assessed the placement of signage to determine its accessibility to both staff and confined individuals, ensuring that it could be easily accessed when needed. The auditor conducted tests on the third-party reporting system either before, during, or after the onsite visit to ensure its functionality and accessibility. A test third-party report was completed and submitted through the same method available to the public, typically via the facility's website. It was confirmed that the method for submitting third-party reports was readily accessible, clearly understood, and specifically designated for reporting incidents of sexual abuse and harassment within the facility. Verification of the facility's process for receiving and responding to third-party reports was sought, and evidence of receiving the test report submitted by the auditor was requested for validation. Informal discussions were held with both staff, residents, and outside reporting entities to gather insights into the effectiveness of facility signage. Corrective Actions: N/A. There are no corrective actions for this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services

PREA Incident Check Sheet

Interviews:

Random Sample of Staff (7)

Director or Designee

PREA Coordinator

Findings (By Provision):

115.261 (a). The agency shall 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; 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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 PREA Policy for FHM Services states that “All staff are required to report any instance of alleged or actual sexual abuse or sexual harassment, retaliation, or staff neglect to the Program Director or on-call supervisor immediately. Staff members shall not reveal any information related to the report to anyone other than the extent necessary” (p. 8).

PREA Incident Check Sheet: the facility has a staff action sheet to address allegations of sexual abuse.

Site Review:

During the site review, the auditor conducted an examination of the staff reporting methods offered by the facility.

A staff member was engaged to walk through the staff reporting process, allowing the auditor to gain a firsthand understanding of its functionality and accessibility.

The availability of the staff reporting method was assessed to ensure it could be

	accessed promptly and as needed by all staff members throughout the facility. Additionally, the auditor evaluated whether staff were mandated to report incidents to their direct colleagues or immediate supervisors, thereby determining the hierarchical structure of the reporting process within the facility. While the expectation is to report to immediate supervisor staff was able to articulate other methods to report. Interviews Random Sample of Staff – The interviewed staff reported that the agency requires all staff 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 of retaliation. Staff could articulate that their responsibility is to report immediately to the supervisor. Corrective Action: N/A. There are no corrective actions for this provision. 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). Apart from reporting to designated supervisors or officials, staff shall not reveal 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “staff members shall not reveal any information related to the report to anyone other than the extent necessary” (p. 8). The policy further states that “the PREA coordinator or designee will ensure appropriate law enforcement is contacted on all criminal matters for investigation. The CTDOC (Parole) shall also be notified of any incidents or allegations of sexual abuse or sexual harassment” (p. 8). Site Review: During the site review, the auditor conducted an assessment of the storage

practices for information and documentation in adherence to the PREA Standards. Client information was stored in the assigned case managers locked office.

The physical storage area for hard copy documentation, including but not limited to risk screening information, medical records, and sexual abuse allegations, was observed to determine the level of security in place.

Attention was given to whether access to this physical storage area was restricted, potentially through mechanisms such as key access.

Interviews

Random Sample of Staff – The interviewed staff reported that the agency requires all staff 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 of retaliation. Staff could articulate that their responsibility is to report immediately to the supervisor.

Corrective Actions:

N/A. There are no corrective actions for this provision.

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 (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.

Compliance Determination:

The site does not have medical and mental health practitioners or services onsite.

Corrective Actions:

N/A. There are no corrective actions for this provision.

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.

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: There are no residents under the age of 18. Interviews Director – The interviewed staff reported that the site does not have residents under the age of 18. PREA Coordinator - The interviewed staff reported that while we do not house clients who are 18 or under, if an allegation was made by an individual 18 or under or by someone considered a vulnerable adult, the facility would report to the PREA Coordinator, and the agency would follow the state mandated reporting laws. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no reports of sexual abuse and sexual harassment reports to investigators. Interviews Director or Designee: The interviewed staff reported that all allegations of sexual abuse and sexual harassment are received and are investigated. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and

	online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services PREA Incident Check Sheet Interviews: Agency Head Director or Designee Random Sample of Staff (7) Findings (By Provision): 115.262 (a). Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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: N/A. The longest amount of time (in hours or days) elapsed before taking action--if not "immediate" (i.e., without unreasonable delay). If not immediately, please explain in the comments section. N/A. Policy: The PREA Policy for FHM Services states that “Upon receiving any information that a resident is subject to any risk of sexual abuse the Program Director will be

	notified, and appropriate action will be taken to protect the resident" (p. 8). PREA Incident Check Sheet: the facility has a staff action sheet to address allegations of sexual abuse. Interviews Agency Head – The interviewed agency head reported that if they learn that a resident is subject to a substantial risk of imminent sexual abuse the agency shall take immediate action to protect the resident. The agency would do so by increasing monitoring of the person and cameras and separate involved parties. Director or Designee – The interviewed staff reported that when they learn that a resident is subject to a substantial risk of imminent sexual abuse the agency shall take immediate action. For example, separate them, investigate and/or have closer to staff. Additionally, the concern would be reported to the Parole Officer and the PREA Coordinator. Random Sample of Staff – The interviewed staff reported that if they learn that a resident is at imminent risk of sexual abuse, they will respond immediately. The various response methods include notifying the supervisor, changing rooms if needed, getting the person out of the situation, monitor and separate from others. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Interviews: Agency head Director or designee 115.263 (a). Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “upon receiving information or allegation that a resident was sexually abused while confined at another facility, the CTDOC (Parole) and, if a Community Confinement facility, the head of that facility will be notified immediately (but no later than 72 hours after receiving the allegation) and an incident report completed documenting notification” (p. 8). Corrective Actions: N/A. There are no corrective actions for this provision. 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). Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “upon receiving information or allegation that a resident was sexually abused while confined at another facility, the CTDOC (Parole) and, if a Community Confinement facility, the head of that facility will be notified immediately (but no later than 72 hours after receiving the allegation) and an incident report completed documenting notification” (p. 8). Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall document that it has provided such notification. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “upon receiving information or allegation that a resident was sexually abused while confined at another facility, the CTDOC (Parole) and, if a Community Confinement facility, the head of that facility will be notified immediately (but no later than 72 hours after receiving the allegation) and an incident report completed documenting notification” (p. 8). Corrective Actions: N/A. There are no corrective actions for this provision. 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). The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. Policy: The PREA Policy for FHM Services states that “upon receiving information or allegation that a resident was sexually abused while confined at another facility, the CTDOC (Parole) and, if a Community Confinement facility, the head of that facility will be notified immediately (but no later than 72 hours after receiving the allegation) and an incident report completed documenting notification” (p. 8). Interviews Agency head – The interviewed agency head reported that the PREA coordinator would be the point person for the investigation. All allegations would be investigated, and the executive team would be updated on the results of the investigation. Director or designee – The interviewed staff reported that if the facility receives a report from another facility or agency that an incident of sexual abuse or sexual harassment occurred at the facility, the incident would be investigated and reported to the other entity. This would be coordinated through the agency PREA Coordinator and the Parole Officer. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Interviews: Security Staff and Non-Security Staff First Responders (7) Findings (By Provision): 115.264 (a). 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: (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, 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; and (4) 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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: N/A. 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: N/A 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: N/A 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: N/A Policy: The PREA Policy for FHM Services states that Reporting Duties: All staff must immediately report to the Program Manager/ supervisory designee, the Executive Director, or any supervisor or manager or senior management staff any knowledge, suspicion, or information regarding: · An incident of sexual abuse or sexual harassment that occurred in the program; · Retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment; · Any staff neglect or violation of responsibilities that may have contributed to such an incident or retaliation. All reports of sexual abuse and sexual harassment that are received from third parties must be received and responded to according to policy by all staff. As soon as practical, FHM must report all allegations of sexual abuse, including third party and anonymous reports, to the local authorities for further investigation: Call 911 to obtain transportation for the resident to Lawrence & Memorial Hospital, which is PREA compliant; When a resident state they have been sexually abused, staff must request that the resident not take any action that could destroy physical evidence, including washing, drinking, or eating, unless medically indicated; If toileting needs to take place, the resident should be instructed to not wipe;

	The Program Manager/supervisory designee must contact The Center for Family Justice to arrange for a sexual assault advocate to go to the hospital where the resident is being transported. All allegations of sexual harassment must be reported for investigation to the PREA Coordinator: Allegations of sexual harassment between residents will be reported for investigation by program staff; Allegations of sexual harassment of residents by staff will be reported for investigation by the Administrative Office of FHM Services. Upon receiving an allegation that a resident was sexually abused while residing at an FHM program, the staff receiving this information must immediately notify the PREA Coordinator, the Program Manager or a supervisor, manager, or senior management staff. The person receiving such notice will immediately notify the PREA Coordinator if the PREA Coordinator was not initially notified; The senior management of FHM must, a) Institute the Incident Report process and b) call the local authorities to begin a criminal investigation. Upon receiving an allegation that a resident was sexually abused the Supervisor/ Manager receiving this information must immediately notify the PREA Coordinator and document such report and notification in the facility log: The PREA Coordinator will keep a record of the details of the notification, including: All persons notified; Date and time of notification; Date and time notice of allegation was received; Any details of the allegation. If the allegations of sexual abuse are reported to staff after the alleged victim has been transported to a medical facility, staff must: Notify the receiving facility of the allegation of sexual abuse and the victim's potential need for medical or social services unless the victim has requested otherwise; Complete an Incident Report in accordance with FHM procedures. Interviews Security Staff and Non-Security Staff First Responders – All of the interviewed staff are considered first responders. The staff was able to articulate the first responder duties, such as securing the scene, getting the parties involved to a safe location, notifying their supervisor immediately or law enforcement, and ensuring that no one contained evidence. Residents who Reported a Sexual Abuse – There were no identified residents who

	reported sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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). If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not to take any actions that could destroy physical evidence and then notify security staff. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency policy requires 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. As reported by the agency all staff are considered first responders. 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: N/A. 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. Policy: The PREA Policy for FHM Services states that “Upon learning of an allegation that a resident was sexually abused, the first responding staff member shall separate the alleged victim and abuser ensuring that neither shower, bathes, eats, drinks, uses the toilet, or changes clothes if the abuse occurred within a time period that allows for the collection of physical evidence (p. 8). Interviews Security Staff and Non-Security Staff First Responders/Random Sample of Staff – The interviewed staff reported that if they are the first person to be alerted that a resident has allegedly been the victim of sexual abuse, their responsibility is to secure the area, take down basic information, take the victim to a safe location, maintain constant supervision of the clients, and complete an incident report. Such actions would be taken immediately. When asked who they would not share the information with the responses varied from other staff and clients. Corrective Actions:

	N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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) FHM PREA Policy Interviews: Director Findings (By Provision): 115.265 (a). The facility shall develop 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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.

	FHM PREA Policy has a Central Coordinated Response is a detailed plan providing an opportunity for staff to document any coordinated actions take to respond to an incident of sexual abuse among staff members, first responders, medical and mental health practitioners, investigators, and facility leadership (p. 8). Interviews Director or Designee – The interviewed staff reported that the facility shall develop a written institution plan. This plan is that everyone should immediately call the PREA Coordinator, call state police and sit with the resident until medical care is rendered. The facility has a checklist for staff to follow that incudes notification and preserving evidence. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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). Neither the agency nor any other governmental entity responsible for

	collective bargaining on the agency's behalf shall enter into or renew 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 agency head reported that the agency has not entered into any collective bargaining agreements. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Nothing in this standard shall restrict the entering into or renewal of agreements that govern: (1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §115.272 and 115.276; or (2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A- Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Interviews: Agency Head Director or Designee Designated Staff Member Charged with Monitoring Retaliation (or Director if nonavailable) Findings (By Provision): 115.267 (a). The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. The PREA Policy for FHM Services provides that “all residents who report sexual abuse or sexual harassment or cooperates with a sexual abuse or sexual harassment investigation will be protected from retaliation by to other resident or staff” (p.10). Corrective Actions: N/A. There are no corrective actions for this provision. 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). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 agency head reported that they would take protective measures of retaliation is identified. Such measures may include increased monitoring, separate parties involved, and increased camera monitoring. Director or Designee - – The interviewed staff reported that they will monitor for changes in behavior. The measures would include having the person come to the office, call the PREA Coordinator and let the Parole Officer determine if staying in the program is safe. W may also recommend housing changes, removal of staff and extra monitoring. Designated Staff Member Charged with Monitor Retaliation – The interviewed staff reported that they will monitor for changes in behavior. The measures would include monitoring for changes in behavior, notifying parole, and separating involved parties. Residents who Reported a Sexual Abuse – There were no identified residents who reported sexual abuse. Corrective Actions: 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 (c). For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct and treatment of residents or staff who reported the sexual abuse and 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,

	and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 beyond 90 days if the initial monitoring indicates a continuing need. The number of times an incident of retaliation occurred in the past 12 months: 0. The PREA Policy for FHM Services states that “the PREA Coordinator shall monitor the conduct and treatment of any resident or staff member who reported the abuse to see if there are changes that may suggest possible retaliation. Monitoring shall continue beyond 90 days if initial monitoring indicates a continued need. Efforts to fulfill monitoring obligations will be documented and controlled by the PREA Coordinator” (p. 10). Interviews Director or Designee – The interviewed staff reported that if there is suspicion of retaliation, the agency would monitor, notify parole, and staff would be removed while the incident is investigated. Designated Staff Member Charged with Monitoring Retaliation – The interviewed staff reported that if retaliation is suspected they would gather all of the facts via documentation along with reporting to the chain of command. I would speak to the residents and the staff and get guidance from the PREA Coordinator and HR. Monitoring would include looking to see how the person is being treated, how they are being spoken too, if they will not come out of their rooms, eat, or take medication. Overall look for a change of behaviors. Monitoring would occur for probably two days and if needed there would not be maximum amount of time to monitor. Corrective Actions: 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.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no allegations of sexual abuse; therefore, there was no documentation of retaliation for monitoring to review. Interviews Designated Staff Member Charged with Monitoring Retaliation (or Director if nonavailable) - The interviewed staff reported that they will monitor for changes in behavior. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no allegations of sexual abuse; therefore, there was no documentation of retaliation for monitoring to review. Interviews Agency Head – The interviewed agency head reported that they would take protective measures of retaliation is identified. Such measures may include increased monitoring, separate parties involved, and increased camera monitoring. Director or Designee – The interviewed staff reported that they would monitor for changes in behavior, by housing changes, removal of staff, contact parole, increase monitoring, and review camera footage. Corrective Actions: N/A. There are no corrective actions for this provision. 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). An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Interviews: PREA Coordinator Investigative Staff (DOC) Director Findings (By Provision): 115.271 (a). When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: As reported in the PAQ, the agency/facility has a policy related to criminal and administrative agency investigations. Policy: The PREA Policy for FHM Services states that: · CRIMINAL AND ADMINISTRATIVE AGENCY INVESTIGATIONS · The PREA Coordinator or designee shall investigate promptly, thoroughly, and objectively all allegations of sexual abuse or sexual harassment including those from a third party. · Any allegation determined to be criminal in nature shall be immediately reported to law enforcement for investigation. If law enforcement determines there is no criminal activity, the facility will conduct its own administrative investigation into the incident. · An administrative investigation shall be documented listing all findings including a determination whether staff actions or failures to act contributed to the incident. · A criminal investigation shall be conducted by law enforcement officials. Facility staff shall cooperate with and assist with any request made by law enforcement. The PREA Coordinator shall endeavor to remain informed about the progress of the investigation (p. 11). · All criminal matters will be referred to and investigated by CT State Police. Interviews Investigative Staff – The interviewed staff stated that Investigations are initiated immediately upon report of an allegation of sexual abuse or sexual harassment and are conducted promptly. All investigations are overseen by the same standards. Anonymous or third-party reports follow the same protocols. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.234. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	The agency reported that they do not conduct sexual abuse or sexual harassment investigations. Interviews Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no identified or reported allegations of sexual abuse or sexual harassment to review. Interviews Investigative Staff – The interviewed staff stated that the first step in initiating an investigation is the Separation of victim and abusers. Preserving evidence. Provide services. These are initiated immediately following an allegation. Incidents are forwarded up the chain of command and authorized for investigation by the PREA Unit. During the course of the investigation, all testimonial and physical evidence is reviewed. Additional interviews are conducted if warranted. Findings determined based on preponderance of evidence. Final reports submitted for final approval by Administration. Closure notifications made to parties involved. Direct physical evidence (clothing or DNA) will be collected at the facility by staff or CSP along with hospital personnel. Statements, video recordings, interviews, and historical information regarding prior allegations not yet obtained will be gathered during investigation. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Investigative Report: There were no criminal-related allegations during the audit period. Investigative Staff – The interviewed staff reported that evidence is forward to CT state police, who would consult with prosecutors. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no identified or reported allegations of sexual abuse or sexual harassment to review. Interviews Investigative Staff – The interviewed staff stated that credibility will be assessed based on each individual person. A polygraph is not required. Residents who Reported Sexual Abuse – There were no reported residents at the site during the onsite audit who had reported sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no reported allegations of sexual abuse or sexual harassment during the audit cycle. Audit Site Review: RECORD STORAGE During the site review, the auditor assessed the storage practices for information and documentation in accordance with PREA Standards. The facility utilizes a paper processing system. Client information was securely stored in the assigned case manager's locked office. Inactive records were kept in a locked office until their destruction, as per the agency's retention policy. The inactive records are accessible exclusively to facility leadership. An informal conversation confirmed that there are no onsite medical or mental health services available. Any referral to services is documented in the client file as mentioned above. Although the facility has not had any PREA allegations, any such allegations or investigation reports would be maintained by the facility PREA Coordinator. Interviews Investigative Staff – The interviewed staff reported that the investigation will Review submitted incident reports and conduct interviews to determine if any actions or lack of actions contributed to the sexual abuse. The investigation would be documented. Facts gathered from incident reports, interviews and statements, video recordings. Findings of allegations along with recommendations if warranted. Corrective Actions: N/A. There are no corrective actions for this provision. 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. There were no reported criminal investigations.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Investigative Report: there were no identified criminal investigations reports during the audit period. Interviews Investigative Staff – The interviewed staff reported that criminal investigations are referred and maintained with Connecticut State Police. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. Policy: PREA Policy for FHM Services states that “a criminal investigation shall be conducted by law enforcement officials. Facility staff shall cooperate with and assist with any request made by law enforcement. The PREA Coordinator shall endeavor to remain informed about the progress of the investigation” (p. 11). There were no reported criminal investigations. Interviews Investigative Staff – The interviewed staff reported that State Police manages referral of cases for prosecution if there is a substantiated allegation of conduct that appears criminal. Corrective Actions: N/A. There are no corrective actions for this provision.

	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). The agency shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. Interviews Corrective Actions: Policy Update: the updated policy provided the above language. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Investigative Staff – The interviewed staff reported that Investigations continue through final determination and review regardless of a staff member’s employment status. The employment status has no bearing on the status of the investigation. The investigation process does not change based on whether the victim or alleged abuser has left the facility. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Director - The interviewed staff reported that if an outside agency investigates allegations of sexual abuse, the facility will remain informed of the progress of the investigation by getting updates from the PREA Coordinator or the Parole Officer. PREA Coordinator – The interviewed staff reported that PREA Coordinator and Facility Director proactively communicate with any outside agency investigation into allegations of sexual abuse. Criminal investigations are managed by the State Police, with whom the agency remains in contact until receipt of a final report. Investigative Staff – The interviewed staff reported that the Facility Director and PREA Coordinator make every effort to remain in communication with the outside agency to get information on the progress of the investigation. The DOC investigator would assist CSP in criminal investigations in whatever capacity is requested. Coordinating interviews. Provide movement information on involved parties. Function as a liaison for information. Administrative investigations are conducted by the agency. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Following analysis, upon review of additional information the facility is compliant with the standard.

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) Policy: PREA Policy for FHM Services Interviews: Investigative Staff (DOC) Findings (By Provision): 115.272 (a). The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency imposes 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. Policy: The PREA Policy for FHM Services states that “the facility shall impose no standard higher than the preponderance of evidence in determining whether allegations of sexual abuse or sexual assault are substantiated” (p. 11). There were no identified or reported allegations; therefore, documentation of administrative findings for proper standard of proof could not be observed. Interviews Investigative Staff – The interviewed staff reported that the agency will impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual harassment are substantiated. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility

	documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services PREA Incident Check Sheet Letter from Chief of Police (2024) Interviews: Director Investigative Saff Findings (By Provision): 115.273 (a). Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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: 0.

	Policy: The PREA Policy for FHM Services states that “It is the policy of FHM residential programs that residents shall be informed of the outcome of an investigation whether the allegation was determined to be substantiated, unsubstantiated, or unfounded. Furthermore, any action taken against a staff member or any knowledge about convictions or criminal charges against a resident abuser shall be reported to the resident victim. All victim notifications will be documented in an incident report” (p. 11). Interviews Director or Designee – The interviewed staff reported that the PREA Coordinator notifies a resident who makes an allegation of sexual abuse when the allegation has been determined substantiated, unsubstantiated, or unfounded following an investigation. Investigative Staff – The interviewed staff reported that following a review into a client / resident’s allegation of sexual abuse the resident would be notified of the results of the investigation. This notification is to be documented. Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process. Corrective Actions: N/A. There are no corrective actions for this provision. 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). If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “a criminal investigation shall be conducted by law enforcement officials. Facility staff shall cooperate with and assist with any request made by law enforcement. The PREA Coordinator shall

	endeavor to remain informed about the progress of the investigation" (p. 11). There were no identified reports where an outside entity conducted an investigation on the site. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever: (1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless unfounded) whenever: o The staff member is no longer posted within the residents' unit; o The staff member is no longer employed at the facility; o The agency learns that the staff member has been indicated on a charge related to sexual abuse within the facility; or o The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Policy: The PREA Policy for FHM Services states that "It is the policy of FHM residential programs that residents shall be informed of the outcome of an investigation whether the allegation was determined to be substantiated, unsubstantiated, or unfounded. Furthermore, any action taken against a staff member or any knowledge about convictions or criminal charges against a resident abuser shall be reported to the resident victim. All victim notifications will be documented in an incident report" (p. 11). There were no identified allegations of sexual abuse or sexual harassment.

	Interviews Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: 1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or 2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. All such notifications or attempted notifications shall be documented. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “It is the policy of FHM residential programs that residents shall be informed of the outcome of an investigation whether the allegation was determined to be substantiated, unsubstantiated, or unfounded. Furthermore, any action taken against a staff member or any knowledge about convictions or criminal charges against a resident abuser shall be reported to the resident victim. All victim notifications will be documented in an incident report” (p. 11). Furthermore, the facility reported that they would use the Documentation Review Worksheet (Investigation and Response Record) form to notify the victim. There were zero allegations of sexual abuse reported at the facility in the last 12 months. Interviews Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process.

	Corrective Actions: N/A. There are no corrective actions for this provision. 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). All such notifications or attempted notifications shall be documented. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “all victim notifications will be documented in an incident report” (p. 11). Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Findings (By Provision): 115.276 (a). Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. The facility has demonstrated compliance with this provision of the standard because: Compliance Determination: 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 PREA Policy for FHM Services states that “Any staff member found in violation of sexual assault will be terminated immediately. Any staff member found to be in violation of sexual harassment shall be subject to disciplinary sanctions up to and including termination. Any staff member found to be guilty of sexual assault will be reported to law enforcement regardless of if the staff member resigns (p. 11). Corrective Actions: N/A. There are no corrective actions for this provision. 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. The facility has demonstrated compliance with this provision of the standard because: Compliance Determination: 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 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 PREA Policy for FHM Services states that “Any staff member found in violation of sexual assault will be terminated immediately. Any staff member found to be in violation of sexual harassment shall be subject to disciplinary sanctions up to and including termination. Any staff member found to be guilty of sexual assault will be reported to law enforcement regardless of if the staff member resigns (p. 11). Corrective Actions: N/A. There are no corrective actions for this provision. 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). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, 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 Policy: The PREA Policy for FHM Services states that “Any staff member found in violation of sexual assault will be terminated immediately. Any staff member found to be in violation of sexual harassment shall be subject to disciplinary sanctions up to and including termination. Any staff member found to be guilty of sexual assault will be reported to law enforcement regardless of if the staff member resigns (p. 11). Corrective Actions: N/A. There are no corrective actions for this provision. 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). 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, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that "Any staff member found in violation of sexual assault will be terminated immediately. Any staff member found to be in violation of sexual harassment shall be subject to disciplinary sanctions up to and including termination. Any staff member found to be guilty of sexual assault will be reported to law enforcement regardless of if the staff member resigns (p. 11). Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Interviews:

	Director Findings (By Provision): 115.277 (a). Any contractor or volunteer who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “Any contractor or volunteer who engages in sexual assault, sexual abuse, or sexual harassment shall be prohibited from contact with residents and local law enforcement will be contacted unless the activity is determined to be non-criminal. Appropriate remedial measures will be taken on violations of sexual abuse or sexual harassment by contractors or volunteer on non-criminal incidents” (p. 12). Corrective Actions: N/A. There are no corrective actions for this provision. 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). The facility shall take appropriate remedial measures and shall consider 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “appropriate remedial measures will be taken on violations of sexual abuse or sexual harassment by contractors or volunteer on non-criminal incidents” (p. 12). Interviews Director or Designee – The interviewed staff reported that if any volunteer or contractor was found guilty of sexual abuse or sexual harassment, they would not be allowed to enter the program. However, the agency does not have volunteers or contractors. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Corrective Action: Policy Update

	Interviews: Director Findings (By Provision): 115.278 (a). Residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 guilty of resident-on-resident sexual abuse has occurred at the facility: 0. Policy: The PREA Policy for FHM Services states that “residents will be subject to disciplinary sanctions or remanded back to the CTDOC following an administrative finding that the resident engaged in sexual assault, sexual abuse, or sexual harassment of another resident. Any resident criminally charged will be returned to the CTDOC (remanded)” (p. 12). Corrective Actions: N/A. There are no corrective actions for this provision. 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 (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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	There were no reported allegations that required sanctions to review. Interviews Director or Designee – The interviewed staff reported that residents shall be subject to disciplinary action pursuant to a formal disciplinary process following an administrative finding that the resident engaged in sexual abuse or following a criminal finding. Disciplinary action shall consider whether or not a resident's mental disability or illness contributed to the behavior. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no reported allegations that required sanctions to review. Interviews Director or Designee – The interviewed staff reported that residents shall be subject to disciplinary action pursuant to a formal disciplinary process following an administrative finding that the resident engaged in sexual abuse or following a criminal finding. Disciplinary action shall consider whether or not a resident's mental disability or illness contributed to the behavior. Corrective Actions: N/A. There are no corrective actions for this provision. 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). If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. 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. Services are referred to a community partner. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. The facility has demonstrated compliance with this provision of the standard because: Compliance Determination: As reported in the PAQ, the agency does not discipline residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. Corrective Actions: Policy Update: Ø Corrective Action Taken: The policy was updated to reflect “FHM Services, Inc. may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact” (p. 10). 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. Compliance Determination: There were no reported allegations that required sanctions to review. The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish sufficient evidence to substantiate the allegation. Corrective Actions:

	Policy Update: Ø Corrective Action Taken: The policy was updated to reflect “FHM Services, Inc. prohibits 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: (p. 10). 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). An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, 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: Reviewing and Responding to Allegations of Sexual Abuse states that “CT Renaissance prohibits all sexual activity between residents and will follow up with disciplinary action for such activity. CT Renaissance will not deem such activity to constitute sexual abuse if it is determined that the activity is not coerced.” (p. 3). Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Corrective Action: Policy Update Interviews: Security Staff and Non-Security Staff First Responders (7) Findings (By Provision): 115.282 (a). Resident victims of sexual abuse shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “victims of sexual abuse will receive timely unimpeded access to emergency medical treatment and crisis intervention services at no cost to the resident regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident” (p. 12). Interviews Medical and Mental Health Staff-The facility does not have medical or mental health staff. Corrective Actions: N/A. There are no corrective actions for this provision.

	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). If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to § 115.262 and shall immediately notify the appropriate medical and mental health practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Security Staff and Non-Security Staff First Responders – All of the direct care staff are first responders. The staff interviewed were responsible for the agency's first responder protocol, which included how to protect the evidence, separate the parties involved, and report to supervisor/ management for further action. Corrective Actions: Policy Update: the policy was updated to reflect the above standard language. 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 (c). Resident victims of sexual abuse while incarcerated shall be 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, resident victims of sexual abuse while incarcerated shall be 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. Policy: The PREA Policy for FHM Services states that "victims of sexual abuse will receive timely unimpeded access to emergency medical treatment and crisis intervention services at no cost to the resident regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. FHM residential programs do not employ medical or mental health staff. Any victim of sexual assault or sexual abuse will be transported to a local hospital for appropriate treatment and information about sexually transmitted diseases in

	accordance with professionally accepted standards of care by SAFE/SANE qualified staff" (p. 12). Interviews Security Staff and Non-Security Staff First Responders – All of the direct care staff are first responders. The staff interviewed were responsible of the agencies first responder protocol, which included how to protect the evidence, separate the parties involved, and report to supervisor/ management for further action. It should be noted that the staff struggled with answering how to properly protect evidence. Corrective Actions: N/A. There are no corrective actions for this provision. 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). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that "victims of sexual abuse will receive timely unimpeded access to emergency medical treatment and crisis intervention services at no cost to the resident regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. FHM residential programs do not employ medical or mental health staff. Any victim of sexual assault or sexual abuse will be transported to a local hospital for appropriate treatment and information about sexually transmitted diseases in accordance with professionally accepted standards of care by SAFE/SANE qualified staff" (p. 12). Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings:

	The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Findings (By Provision): 115.283 (a). The facility shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility does not 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. Policy: The PREA Policy for FHM Services states that “Continued medical and mental health treatment for victims and abusers will be provided by CTDOC or local medical facilities as deemed appropriate at no cost to the resident(s)” (p. 12). Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no identified victims of sexual abuse to review information. Interviews Medical and Mental Health Staff – the facility does not have medical or mental health staff. Residents who Reported a Sexual Abuse – There were no identified residents who reported sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no identified victims of sexual abuse to review information. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, 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 PREA Policy for FHM Services states that “Continued medical and mental health treatment for victims and abusers will be provided by CTDOC or local medical facilities as deemed appropriate at no cost to the resident(s)” (p. 12). Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no identified victims of sexual abuse to review information. Interviews: Residents of Sexual Abuse: There were no residents of sexual abuse at the facility during the onsite audit period. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	Policy: The PREA Policy for FHM Services states that “CTDOC policy states it will conduct mental health evaluation within 60 days on all known resident-on-resident abusers” (p. 12). Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services PREA Incident Check Sheet Document Review Worksheet (Sexual Abuse Incident Review (SAIR) Records) Interviews: Director PREA Coordinator Incident Review Team (1) Findings (By Provision): 115.286 (a). The facility shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “The PREA Coordinator in consultation with the Incident Review Team including each Program Director and Assistant Program Director will conduct an incident review within 30 days of the conclusion of all sexual abuse investigations including allegations that are found to be unsubstantiated” (p. 12). Document Review Worksheet (Sexual Abuse Incident Review (SAIR) Records): The purpose of this form is to systematically review and document all incidents of alleged sexual abuse within the facility. The worksheet ensures that each case is thoroughly examined, even if the allegation has been determined to be unsubstantiated. The review process, conducted by the PREA Coordinator in consultation with the Incident Review Team, helps identify any potential issues, compliance with policies, and areas for improvement. The goal is to maintain a safe environment, uphold standards, and ensure proper procedures are followed. There were no reported or identified allegations of sexual abuse to assess and review. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Such review shall ordinarily occur within 30 days of the conclusion of the investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 were followed by a sexual abuse incident review within 30 days, excluding only “unfounded” incidents: 0. Policy: The PREA Policy for FHM Services states that “The PREA Coordinator in consultation with the Incident Review Team including each Program Director and Assistant Program Director will conduct an incident review within 30 days of the conclusion of all sexual abuse investigations including allegations that are found to be unsubstantiated” (p. 12). Document Review Worksheet (Sexual Abuse Incident Review (SAIR) Records): The purpose of this form is to systematically review and document all incidents of alleged sexual abuse within the facility. The worksheet ensures that each case is thoroughly examined, even if the allegation has been determined to be unsubstantiated. The review process, conducted by the PREA Coordinator in consultation with the Incident Review Team, helps identify any potential issues, compliance with policies, and areas for improvement. The goal is to maintain a safe environment, uphold standards, and ensure proper procedures are followed. There were no reported or identified allegations of sexual abuse to assess and review. PREA Annual Report: the 2024 PREA Annual Report was reviewed showing the agency overall review of allegations of sexual abuse and sexual harassment. Corrective Actions: N/A. There are no corrective actions for this provision. 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 review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, 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 PREA Policy for FHM Services states that “The PREA Coordinator in consultation with the Incident Review Team including each Program Director and Assistant Program Director will conduct an incident review within 30 days of the conclusion of all sexual abuse investigations including allegations that are found to

	be unsubstantiated" (p. 12). It was further reported that the SAIR form would be used to document the incident review. Document Review Worksheet (Sexual Abuse Incident Review (SAIR) Records): The purpose of this form is to systematically review and document all incidents of alleged sexual abuse within the facility. The worksheet ensures that each case is thoroughly examined, even if the allegation has been determined to be unsubstantiated. The review process, conducted by the PREA Coordinator in consultation with the Incident Review Team, helps identify any potential issues, compliance with policies, and areas for improvement. The goal is to maintain a safe environment, uphold standards, and ensure proper procedures are followed. There were no reported or identified allegations of sexual abuse to assess and review. Interviews Director or Designee – The interviewed staff reported that they are not sure as they are not part of the team, however they would go back and review. The Director further reported that all of the above will be taken into consideration. Corrective Actions: N/A. There are no corrective actions for this provision. 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). 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; 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; (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 limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA Coordinator. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that "The Incident Review Team shall 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 was motivated or otherwise caused by a group of dynamics at the facility. The Incident Review Team shall examine the area where the incident allegedly occurred to assess whether physical barriers in the area enabled the abuse; assess staffing levels; assess use of monitoring equipment; and prepare a report of its findings and recommendations for improvement" (p. 12). Document Review Worksheet (Sexual Abuse Incident Review (SAIR) Records): The purpose of this form is to systematically review and document all incidents of alleged sexual abuse within the facility. The worksheet ensures that each case is thoroughly examined, even if the allegation has been determined to be unsubstantiated. The review process, conducted by the PREA Coordinator in consultation with the Incident Review Team, helps identify any potential issues, compliance with policies, and areas for improvement. The goal is to maintain a safe environment, uphold standards, and ensure proper procedures are followed. Interviews Director – The interviewed staff reported that all of the above will be taken into consideration. PREA Coordinator – The interviewed staff reported that Sexual abuse incident reviews are overseen by the PREA Coordinator in collaboration with the Facility Director and staff. The review process specifically considers any needed changes, including: if there is a need to modify policy or practice, whether the incident/ 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; an assessment of the area in the facility where the incident allegedly occurred; adequacy of staffing levels in the area during different shifts; and whether monitoring technology should be deployed or augmented to supplement supervision by staff. The review and recommendations are documented. Incidents are then summarized in an annual report. Yes, if a facility conducts an incident review the report would be sent to me. No incidents were reported. Incident Review Team - The interviewed staff reported that Incident Reviews are completed and documented During each incident review, the team considers when 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. We would look to see if the camera system addressed all areas, staffing

	was available, and if the resident was appropriately placed. Corrective Actions: N/A. There are no corrective actions for this provision. 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 (e). The facility shall implement the recommendations for improvement or shall document its reasons for not doing so. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility implements recommendations for improvement or documents and its reasons for not doing so. Policy: The PREA Policy for FHM Services states that “based on the review of an incident, appropriate corrective actions shall be taken as determined by the Incident Review Team” (p. 13). Document Review Worksheet (Sexual Abuse Incident Review (SAIR) Records): The purpose of this form is to systematically review and document all incidents of alleged sexual abuse within the facility. The worksheet ensures that each case is thoroughly examined, even if the allegation has been determined to be unsubstantiated. The review process, conducted by the PREA Coordinator in consultation with the Incident Review Team, helps identify any potential issues, compliance with policies, and areas for improvement. The goal is to maintain a safe environment, uphold standards, and ensure proper procedures are followed. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Document Review Worksheet (Sexual Abuse Incident Review (SAIR) Records) Findings (By Provision): 115.287 (a). The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that the facility shall prepare an annual report of its findings and corrective actions. The report shall include a comparison of the current year's data with those of previous years and shall provide an assessment of the facility's progress in addressing sexual abuse. Document Review Worksheet (Sexual Abuse Incident Review (SAIR) Records): The facility has demonstrated compliance with this provision of the standard because: it uses the form to document 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. Corrective Actions: N/A. There are no corrective actions for this provision. 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.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Annual Report (standard 115.286) provides aggregate data of the allegations of sexual abuse and sexual harassment. Corrective Actions: N/A. There are no corrective actions for this provision. 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). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “the FHM residential programs shall collect data and maintain records of all incidents related to sexual abuse and sexual harassment whether alleged or actual. The 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” (p. 13). Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	As reported in the PAQ, 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 PREA Policy for FHM Services states that “the FHM residential programs shall collect data and maintain records of all incidents related to sexual abuse and sexual harassment whether alleged or actual. The 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” (p. 13). Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. N/A the agency does not contract for the confinement of its residents. 115.287 (f). Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. N/A the DOJ has not requested agency data. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services

	Website: FHMServices.org Website: Search Results Interviews: Agency Head PREA Coordinator Findings (By Provision): 115.288 (a). The agency shall 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 problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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: The PREA Policy for FHM Services states that “the FHM residential programs shall collect data and main records of all incidents related to sexual abuse and sexual harassment whether alleged or actual. The 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 (p. 13). The agency website is being updated to allow the annual report to be viewed online. Currently, the annual report is available in the lobby for public viewing. Any corrective action plans are addressed on the agency annual report. Interviews: Agency Head – The interviewed agency head reported that following the report of an allegation, an incident review is conducted to determine how the incident occurred and make steps to prevent the possibility of abuse or harassment happening. We would use the information to determine where the weaknesses are and what we can do to make thing better. Ex. Adding camera, reviewing locations where residents have access. Review to see if a mistake was made on putting two residents together.

	PREA Coordinator – The interviewed staff reported that the data and annual reports are reviewed by leadership and made available through the DOC agency website. Upon review it was further determined that the information is not on the agency website. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Such report shall include a 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 provides an assessment of the agency’s progress in addressing sexual abuse. Annual Report (2024): the annual report was reviewed and found to have provided data and corrective actions for prior years. The agency website is being updated to allow the annual report to be viewed online. Currently, the annual report is available in the lobby for public viewing. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency's report shall be approved by the agency head and made readily available to the public through its Web site or, if it does not have one, through other means. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency makes its annual report readily available to the public at least through its website. The annual report is approved by the agency

	head. Policy: The PREA Policy for FHM Services states that “this data, minus redactions, shall also be provided to the CT DOC for inclusion in their annual report” (p.13) The agency website is being updated to allow the annual report to be viewed online. Currently, the annual report is available in the lobby for public viewing. Interviews Agency Head – The interviewed agency head reported that they approve the annual reports. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “prior to making the data public, all personal identifiers shall be redacted. This data, minus redactions, shall also be provided to the CT DOC for inclusion in their annual report” (p. 13). Annual Report: upon review of the annual report, there are no identifiers provided that could pose a threat to safety and security at the facility. Interviews: PREA Coordinator- The interviewed staff reported that prior to making the data available on the website, all personal identifiers are removed. The facility may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility. The nature of the material redacted would need to be indicated. Corrective Actions: N/A. There are no corrective actions for this provision.

	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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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: PREA Policy for FHM Services Website: FHMServices.org Interviews: PREA Coordinator Findings (By Provision): 115.289 (a). The agency shall ensure that data collected pursuant to § 115.287 are securely retained. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “FHM residential programs shall collect data and maintain records of all incidents related to sexual abuse and sexual harassment whether alleged or actual. The 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: (p. 13). Interviews PREA Coordinator – The interviewed staff reported that the PREA Coordinator issues an annual report with aggregated data for the agency and each facility in order to assess and improve the effectiveness of its sexual abuse response. The report includes comparisons of data across years, identification of problem areas, evaluation of corrective actions, and the overall quality of the agency's sexual abuse response. Facility level data is included in the report. The reports are available to the DOC website. Corrective Actions: N/A. There are no corrective actions for this provision. 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). The agency shall 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 Web site or, if it does not have one, through other means. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which its contracts be made readily available to the public at least annually. Corrective Actions: N/A. There are no corrective actions for this provision. 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). Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “prior to making the data public, all personal identifiers shall be redacted. This data, minus redactions, shall also be provided to the CT DOC for inclusion in their annual report” (p. 13). Corrective Actions: N/A. There are no corrective actions for this provision. 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). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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 PREA Policy for FHM Services states that “records will be maintained for at least 10 years after the date of initial collection” (p. 13). Interviews: PREA Coordinator - Prior to making the data available on the website, all personal identifiers are removed. The facility may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility. The nature of the material redacted would need to be indicated. Corrective Actions: N/A. There are no corrective actions for this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility,

	facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Website Findings (By Provision): 115.401 (a). The agency website contains the results of all the PREA audits conducted. 115.401 (b). The site is in Cycle 4 Audit Year 3. 115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the site by the program lead. 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. 115.401 (i). 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. 115.401 (m). The auditor was provided private rooms throughout the site 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 inmate 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. A review of the appropriate documentation and interviews with staff indicate that the site is in compliance with the provisions of this standard. No corrective action is warranted.

	115.401 (n). Residents were able to submit confidential information via written letters to the auditing agency PO Box or during the interviews with the auditor. The auditor did not receive any correspondence from the site. Final Analysis: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with the standard.

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Website Findings (By Provision): 115.403 (a). The agency posts its PREA Audit reports on the Department of Corrections website. The reports are available for review at Search Results . There is a link to the final PREA reports. The facility is compliant with the intent of the standard. Analysis: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with the 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	na

	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.)	
	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	yes

	staffing patterns?	
	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,	yes

	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?	
	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	yes

	force, or coercion, or if the victim did not consent or was unable to consent or refuse?	
	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	**Hiring and promotion decisions**	

(f)		
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	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	yes

	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.)	
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	yes

	residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	
	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,	yes

	does the agency provide refresher information on current sexual abuse and sexual harassment policies?	
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	na

	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)).	
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	na

	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.)	
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:	yes

	Whether the resident's criminal history is exclusively nonviolent?	
	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	**Use of screening information**	

(f)		
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (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.)	yes
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve	yes

	with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	
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.)	yes
	Does the agency ensure that: such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
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.)	yes
	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.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes
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.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf	yes

	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.)	
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	yes
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.)	yes
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.252 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to	yes

	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.)	
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	yes

	information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	
	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,	yes

	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?	
	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	yes

	evidence, including any available physical and DNA evidence and any available electronic monitoring data?	
	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	**Criminal and administrative agency investigations**	

(h)		
	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	yes

	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.)	
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	yes

	the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	
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	yes

	condition of access to programming and other benefits?	
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	yes

	about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	
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	na

	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.)	
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	**Data collection**	

(c)		
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
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.)	na
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes
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	yes

	same manner as if they were communicating with legal counsel?	
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.)	no