PREA Facility Audit Report: Final

Name of Facility: Renaissance Central
Facility Type: Community Confinement
Date Interim Report Submitted: NA
Date Final Report Submitted: 06/24/2025

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:** 06/24/2025

AUDITOR INFORMATION	
Auditor name:	Davis, Latera
Email:	laterad@yahoo.com
Start Date of On-Site Audit:	03/12/2025
End Date of On-Site Audit:	03/13/2025

FACILITY INFORMATION	
Facility name:	Renaissance Central
Facility physical address:	24 Central Avenue, Waterbury, Connecticut - 06702
Facility mailing address:	

Primary Contact

Name:	Katie Seto
Email Address:	kseto@ctrenaissance.org
Telephone Number:	4752259089

Facility Director	
Name:	Katena Billings
Email Address:	kbillings@ctrenaissanc.org
Telephone Number:	2035967303

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

Facility Characteristics	
Designed facility capacity:	45
Current population of facility:	43
Average daily population for the past 12 months:	40
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+
Facility security levels/resident custody levels:	level 1
Number of staff currently employed at the facility who may have contact with residents:	13
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	2
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Connecticut Renaissance, Inc. Headquarters
Governing authority or parent agency (if applicable):	
Physical Address:	One Waterview Drive, Suite 202, Shelton, Connecticut - 06484
Mailing Address:	
Telephone number:	203-336-5225

Agency Chief Executive Officer Information:	
Name:	Kathleen Deschenes
Email Address:	kdeschenes@ctrenaissance.org
Telephone Number:	203-336-5225 ext 222

Agency-Wide PREA Coordinator Information

Name:	Katie Seto	Email Address:	kseto@ctrenaissance.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:	2025-03-12
2. End date of the onsite portion of the audit:	2025-03-13

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	JDI Connecticut Alliance Against Sexual Violence Local Advocacy center (Safe Haven)

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	45
15. Average daily population for the past 12 months:	40
16. Number of inmate/resident/detainee housing units:	3
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:	43
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:	1
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:	1
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:	1
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:	0
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:	1

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:	1
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:	1
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):	Over the past 12 months, the facility has housed a diverse population of residents. The auditor was able to review intake assessments to verify the population characteristics. It should be noted that the above targeted residents identified comprised of two residents.
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:	12
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:	The facility had a diversity in terms of age, gender, ethnicity and background of staff, volunteers and contractors. While the facility had a high turnover rate, there was a range of experience and expertise among staff. The facility employed a versatile staff force that had notable qualification and specialized skills to contribute to the overall facility operations.

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?	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.
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):	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.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	2
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/ resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/ residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
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:	1
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:	1
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).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.

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).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.
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:	1
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:	1

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).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.
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:	1
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).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.
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, 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.
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):	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. All staff scheduled to work were interviewed.

Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	14
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.	There were no identified contractors or volunteers.

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).	The Community Release Programs are provided at three locations located in Waterbury and Bridgeport, serving male clients referred by the Connecticut Department of Correction. Goals of the programs are to offer residents the opportunity to learn how to overcome barriers to reentry, establish vocational and educational skills, support systems and independent living skills. The program begins with an orientation phase which will assist residents with adjusting to the facility, staff members, other residents, structure of the program and to establish a personalized reentry plan that includes measurable criteria of accomplishments and a specific timetable for achieving them. It is the philosophy of the program that discharge begins at admission. During this time, residents will meet with the Unit Job Developer for assessment and support in obtaining and retaining employment. Residents will also be introduced to the Evidence Based Model Life after Incarceration. The program is geared toward assisting clients in recognizing and addressing barriers to successful reintegration. Through one-on-one Case Management residents are encouraged to address their mental health, medical and substance abuse issues. Case Managers aid residents in accessing resources for vocational/educational opportunities, individual and group therapy, 12 step self-help programs, family reunification and legal issues. Length of Stay is approximately 90-120 days. Once a resident is employed, the Case Manager will work with him to learn budgeting and financial literacy. It is the goal of this phase to focus on discharge planning. Completion of the program is based on the client's participation level, employment, securing of appropriate residence, aftercare planning and legal status. Residents are under the supervision of a house Parole Officer. The Parole Officer works closely with the resident and staff to ensure self-sufficiency and success in reentry. Site Review is noted

	throughout the audit.
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:	There were no identified allegations

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:	There were no identified allegations.
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.	There were no identified allegations.

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
96. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1

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: Prison Rape Elimination Act (PREA) Agency Organization 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: · Per 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 sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. · Policy: Prison Rape Elimination Act. The policies mandate a zero tolerance toward all forms of sexual abuse and sexual harassment (p. 1). The policies outlined the approach to prevent, detect, and response to sexual abuse and sexual harassment. The policy further defines sexual abuse and sexual harassment (pp.1-7). Additionally, the policy includes the definition of sexual abuse and sexual harassment, and sanctions for those to have participated in prohibited behaviors 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 the PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. The position of the PREA Coordinator is the "PREA Coordinator". · Policy: Prison Rape Elimination Act. The agency/facility has PREA policies which

	ensure the sexual safety of facility residents and staff. The policy includes zero-tolerance philosophy from the agency central office through the front-line staff in its facilities. The agency/facility PREA coordinator has direct access to the head of the agency and regular communication with the senior leadership team. · Agency Organization Chart: As reported on the organization chart, the agency PREA Coordinator title is: Clinical Performance & Outcomes Director and PREA Coordinator. The position reports to the Chief Operating Officer. 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, handling administrative investigations, answering questions about PREA and CT Renaissance's PREA response, and generally reinforcing the agency's zero tolerance policy and client safety. PREA training is provided monthly to new hires, monitor PREA documentation in our programs, and ensure PREA compliance. 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. 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) Findings (By Provision): 115.212 (a). As reported in the PAQ, the agency has not entered or renewed any contract for the confinement of residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency/facility does not contract with another entity for the confinement of its Residents. · 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). As reported in the PAQ, the agency policy does require the agency to monitor contracts if they have them. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.212(c). As reported in the PAQ, the agency has not entered or renewed any contract for the confinement of residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: · 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: Supervision and Monitoring-Staff Staffing Plan Assessment (2024/2025) Staffing Plan (2024/2025)Layout of Facility Staffing Schedule 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: 40. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents on which the staffing plan was predicated: 45. · Staffing Plan and Staffing Plan Assessment (1/2025): provides documentation of the agency staffing plan and annual assessment that was completed on 1/ 13.2025) · 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 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: The auditor observed that the number of staff and residents varied throughout the day. During the day hours there were more staff present as the administrative staff were also onsite. It should also be noted that the residents worked at various times of the day, therefore the number of residents onsite consistently varied. The staff have camera observation via their computers. Additional administrative staff are onsite in the administrative area which is adjacent to the resident housing area. The facility had signs located in restrooms or door areas where residents are not allowed. Residents' ability to access the administrative area has signage indicating that they must knock and seek staff permission to enter the area. Residents have to be supervised at all times in the administrative area. Additionally, areas were residents were not allowed required staff badge access. It should also be noted that not all staff had access to the building depending on their position.

	The housing unit is organized in a dormitory style, consisting of single and multi-occupant rooms. Rooms were located on Observations of the room checks revealed that these checks are conducted every hour. Female staff announced their presence upon entering the housing area by knocking on the door and informing the occupants about the room check and female entry. The room checks are performed every two hours during the day shifts, hourly for all other shifts, and documented accordingly. When inspecting the bathroom, staff inquired about the occupants and did not enter the bathroom without confirmation. Multiple cameras were strategically installed in all hallways, common areas, exterior corners, kitchenette, basement, gym, and TV room. The auditor inspected the cameras to confirm their functionality and assess the field of view provided by the camera system. Additionally, a mirror was positioned near the staff office and in the resident hallway area, enabling staff to monitor the hallways, thus addressing any potential blind spots near the staff office. There are at least two COD staff on each shift. Informal Conversation: During informal conversations with staff, it was reported that the staff observe residents via camera all day and they conduct hourly rounds. During informal conversations with staff, it was reported that staff conduct rounds throughout the day. Overall, the residents reported feeling safe. Interviews PREA Coordinator: The staff interviewed reported that Staffing plans are assessed for resident sexual safety at least annually and reviewed by the Director of Work Release, the Facility Director and the PREA Coordinator. 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. The staffing plan is kept in a binder on site. In addition, by contract, our Work Release facility must ensure certain staffing levels, so there are no deviations of the staffing plan reported. Our location is adequately monitored by video surveillance which has the ability to play back videos. At least once a year, assessments of video monitoring needs are conducted including analyzing the number of cameras, the placement, and monitoring/dependability of systems. In addition to the annual update of the facility staffing plan, any changes that may be needed throughout the year are overseen by the PREA Coordinator, in consultation with the Director of Work Release and Facility Director. 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.

	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. · 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. The facility has a monthly schedule, so planning is one month in advance. If needed there is an on-call schedule to relieve for call outs. 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. · Policy: Supervision and Monitoring-Staffing outlines the agency procedures for completing the staffing plans (p. 1). · 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: Searches Facility and Person CT Renaissance Training Cross-Gender and Transgender Pat Searches Copy of Pat Search Steps PREA Training Curriculum Searches Training Staff Sign Off (12) Resident Handbook Interviews: Resident Interview Questionnaire (11) Random Sample of Staff (7) Transgender/Intersex (1) 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: Searches Facility and Person states that: o As per the Department of Correction and CSSD contractual agreements, all clients returning to the building from Community passes are to be Pat-Down Searched. This does not include a client returning from a supervised smoke break or recreation unless a client was unobserved or had contact with the public. Cross gender pat-down searches will be conducted only in exigent circumstances. Exigent circumstances means any set of temporary and unforeseen circumstances that require immediate action in order to combat a threat to the security or institutional order of a facility. Pat down searches will be conducted as follows: 1. All Clients will enter the building through a central door. 2. Designated staff will process and search one client at a time. 3. Clients will be signed in by staff. 4. Client will remove hat, coat, shoes and any items on person (including bags, backpacks, etc) Staff will search those items. 5. Client will be asked to move to a designated pat down area (this will be conducted in an area visible by video camera) 6. Pat down search will be conducted by same gender staff 7. When, in exigent circumstances, a cross-gender pat down search occurs, documentation shall be completed and submitted to DOC and the Clinical Performance and Outcomes Department. 8. All applicable staff will be trained in Pat down search procedures upon hire and will be observed by Program Director or designee for competency in the pat-down procedure. This observation will be documented in the staff supervision file. 9. All applicable staff will participate in, at a minimum, an annual retraining in Pat down search procedures or as contractual agreement dictates. 10. All staff is prohibited from searching a transgender or intersex client for the purpose of determining genital status (p. 3). · Audit Site Review: o The auditor observed the area in which pat down searches are conducted. The site does not conduct strip searches however resident are pat searched when entering the facility. The staff requested the residents to take off shoes and to empty their pockets. A male staff conducted the pat down search. The searches must occur within line site of the camera. Searches are documented in a logbook. o The auditor asked two residents about the search process and was informed that female staff rarely search them. However, the facility logs when female staff

	conducts 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. · Resident Handbook: The resident handbook provides the client of an overview of when and how pat searches are conducted. 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: Searches and Facility Person states that “Staff shall conduct and document a search of a client's person only when there is reason to believe the client is in possession of contraband and or stolen property” (p. 2). 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. · 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: Searches of Facility and Person states that “All Agency staff is prohibited from viewing residents while dressing, showering or performing bodily functions” (p. 1). Site Review:

	o 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. Staff are not in direct line site of residents when they dress, shower or toilet. Residents can utilize the bathroom and shut the door without interruption of staff. o 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 in the unit” or just “female”. o 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. o 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. The new process allows for resident screening assessments are maintained electronically. o Electronic surveillance monitoring is conducted in the COD office and through leadership computers/phones. Staff of the opposite gender are assigned to monitor video surveillance; however, the system does not have access to bedrooms or bathrooms. Residents cannot be seen in a state of undress. o Informal conversation with the residents and two residents reported that they feel safe, and that staff is present at all times. The residents stated that staff always make opposite gender announcements, and no one sees them changing clothes, in shower or using the toilet. o Informal discussion with the staff revealed that all personnel have access to the camera system for conducting supplementary observations. Interviews Resident Interview Questionnaire – The interviewed residents reported that female staff announce their presence when entering the housing area. One resident further stated that the PM shift is not as consistent with making announcements. 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 – Seven staff were interviewed during the audit period. Five staff interviewed stated they announce themselves when entering the housing area of residents as well as knock to give residents time to get dressed if needed. Two

	staff members stated that they sometimes will not announce. Six confirmed that residents can dress, shower, and use the toilet privately in their own bathrooms. One staff member mentioned that residents could be undressed during rounds if staff do not announce or knock. 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: Searches of Facility and Person states that “All staff is prohibited from searching a transgender or intersex client for the 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 – The interviewed resident reported that there was no separate housing; however, they were placed in a single 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.

	115.215 (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, 100% 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. · 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. · CT Renaissance Training Cross-Gender and Transgender Pat Searches provides the agency steps for conducting said searches. · PREA Searches Training (12) 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. There are no female residents at the facility. The facility has procedure that only male staff would conduct pat-down searches on male residents. Female staff would perform visual checks, or they would use the wand for 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. 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) Policy: Admission and Orientation Language Line/Language Line Brochure Staff PREA Training Sign Off (7) Resident Handbook Written Material (Brochure-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 Prison Rape Elimination Act (PREA) Policy states that "The agency prohibits the use of residents as interpreters in matters regarding allegation of sexual abuse/harassment during an internal investigation, unless the delay could compromise the resident's safety. The agency has identified a staff member for Spanish speaking individuals who would be able to provide interpreter assistance as needed. The Agency will provide materials related to the zero-tolerance policy in the language of current limited English proficient residents. The agency will create a system for staff to access alternative language lines for additional interpretive services. Information regarding access to the Language Line is available in the PREA Binder available through the program Director or in the COD office. In the case of a LEP client (limited English proficiency) or disabled person unable to read and/or understand the written PREA policy, a staff member will read the PREA policy and elicit responses to confirm that the person understands the policy. Someone who is severely disabled may meet our exclusionary criteria for admission. (p. 1).

· Policy: Admission and Orientation Work Release Programs states that "The program shall provide orientation and information in a manner of which can be understood by the person served. Information shall be in formats that are accessible to those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as those who have limited reading skills" (p. 2).

· Contracts for Interpreter Services: The facility does not have a contract for interpreter services however has access to said services through LEP Language Line.

· Resident Handbook: The resident handbook provides information to residents that the they can seek assistance from staff if there is a need for language or literacy assistance.

· Written Material (Brochure-English/Spanish)

· Staff Training: Staff receive training on working with individuals with disabilities during the PREA training. The auditor reviewed documentation on (12) new hire

	training records to verify compliance. · Site Review: o The auditor evaluated the facility's process for securing interpretation services on-demand. The auditor contacted the language line and determined that the services worked properly. It should be noted that residents have their own cellphones to use as well. o Residents do not have to self-identify when using the language line. The line only requires an agency code to access interpretation services. o The services were available immediately upon call and request. o Due to the cost of accessing interpretation services, the language line has to be set up with the Director; however, residents have immediate access to multiple bilingual staff to immediately interpret the most common language of Spanish. o During informal conversations with staff, it was reported that the agency has a bilingual case manager that is housed at another program onsite; along with several bilingual Spanish speaking staff onsite at the program. o The case managers were able to readily state that they would seek interpreter services if needed. Interviews Agency Head – The interviewed agency head reported that the agency has a partnership with interpreter services. The most common secondary language is Spanish and typically have Spanish speaking staff at all sites. For disabilities we would partner with one of our community providers. Residents (with disabilities or who are limited English proficient) – One resident was identified and interviewed. The resident reported that the placement provides clear and easily understandable information about sexual abuse and harassment. They also felt comfortable asking staff to clarify any information if something was confusing. Furthermore, they were given the opportunity to speak one on one with case manager and review handbook during the intake process upon their arrival at the facility. The resident stated that a staff member would be willing to assist them in understanding information about sexual abuse or harassment if they had questions or didn't understand. They also expressed that they felt comfortable asking a staff member for help if they needed 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.

	115.216 (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 Prison Rape Elimination Act (PREA) Policy states that "The agency prohibits the use of residents as interpreters in matters regarding allegation of sexual abuse/harassment during an internal investigation, unless the delay could compromise the resident's safety. The agency has identified a staff member for Spanish speaking individuals who would be able to provide interpreter assistance as needed. The Agency will provide materials related to the zero-tolerance policy in the language of current limited English proficient residents. The agency will create a system for staff to access alternative language lines for additional interpretive services. Information regarding access to the Language Line is available in the PREA Binder available through the program Director or in the COD office. In the case of a LEP client (limited English proficiency) or disabled person unable to read and/or understand the written PREA policy, a staff member will read the PREA policy and elicit responses to confirm that the person understands the policy. Someone who is severely disabled may meet our exclusionary criteria for admission. (p. 1). · Policy: Admission and Orientation Work Release Programs states that "The program shall provide orientation and information in a manner of which can be understood by the person served. Information shall be in formats that are accessible to those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as those who have limited reading skills" (p. 2). · Contracts for Interpreter Services: The facility does not have a contract for interpreter services however has access to said services through LEP Language Line. · Written Material (Brochure-English/Spanish) · PREA Training: The PREA training material as discussed in standard 115.231 addresses working with vulnerable populations. · Staff Training: PREA Training documented in Standard 115.231. The training curriculum addresses working with residents who are disabled and/or limited English

	Proficient. · Site Review (same as a). Interviews Residents (with disabilities or who are limited English proficient) – One resident was identified and interviewed. The resident reported that the placement provides clear and easily understandable information about sexual abuse and harassment. They also felt comfortable asking staff to clarify any information if something was confusing. Furthermore, they were given the opportunity to speak one on one with case manager and review handbook during the intake process upon their arrival at the facility. The resident stated that a staff member would be willing to assist them in understanding information about sexual abuse or harassment if they had questions or didn't understand. They also expressed that they felt comfortable asking a staff member for help if they needed 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. 115.216 (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 Prison Rape Elimination Act (PREA) Policy states that “The agency prohibits the use of residents as interpreters in matters regarding allegation of sexual abuse/harassment during an internal investigation, unless the delay could compromise the resident’s safety.” (p. 1). · 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. All seven staff stated they would seek assistance from another staff member for interpretation. Residents (with disabilities or who are limited English proficient) – One resident was identified and interviewed. The resident reported that the placement provides clear and easily understandable information about sexual abuse and harassment. They also felt comfortable asking staff to clarify any information if something was confusing. Furthermore, they were given the opportunity to speak one on one with case manager and review handbook during the intake process upon their arrival at the facility. The resident stated that a staff member would be willing to assist them in understanding information about sexual abuse or harassment if they had questions or didn't understand. They also expressed that they felt comfortable asking a staff member for help if they needed 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. 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: Prison Rape Elimination Act Policy: Employment (2024) Personnel File (6 new hires): · New Hire Orientation Checklist · Reference Check Form (3) · Internal Career Application · PREA-Employment Questionnaire · Employment Application · Background Check · Staff PREA Understanding Workplace code of conduct 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: Employment provides guidance on the hiring process for employees. · Personnel Files (6). 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: Employment states that “Connecticut Renaissance will consider any prior reported incidents of sexual harassment in determining whether to hire, appoint, or promote an individual who may have contact with a person in the custody of the Judicial Branch or the Department of Correction” (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. Discussion: A review of 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: 3. · Policy: Employment provides guidance on the hiring process for employees. · Personnel Files (6). Personnel files were reviewed and verified that criminal record background checks were conducted and questions regarding pat conduct were asked and answered. · Prior Institutional Reference Check: there were three identified staff who required a prior institutional reference check. 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 Employee policy states that “Criminal Record Checks shall be completed prior to hire and every 5 years thereafter for all potential employees, volunteers, interns and contractors”. (p. 4).

	· 5- year background check. There were no staff employed who had been hired for five years, therefore five-year background checks were not reviewed. However, the agency has a process in place to conduct five-year background checks. 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 (5) 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. · Policy Employment states that “Omissions on the part of the employee, volunteer, intern or contractor or the provision of materially false information, shall be grounds for termination (p. 2). 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) IMC LLC. 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. 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. The agency typically looks at lighting, video surveillance and hidden corners. We review the layout and assess for blind spots. An example would be when we added a bathroom clear curtain on the bottom and top were included for the shower area. Director or Designee – The interviewed staff reported that there has been no substantial expansions or modifications to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later. 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 (IMC, LLC). 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. The IT director regularly updates the system and will check for blind spots. We look to see how we can upgrade and verify clarity on the camera footage. 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. I think the last one was four months ago. Maybe 12 to 16 or 17 cameras. 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: Reviewing and Responding to Allegations of Sexual Abuse (Reviewed: 2022) Policy: Data Collection and Review of Sexual Abuse and/or Sexual Harassment Incidents (Reviewed: 2025) Policy: Medical and Mental Health Care for Victims of Sexual Abuse (Reviewed 2025) MOU: Safe Haven of Greater Waterbury (2016/2020) Safe Haven Info Sheet Waterbury Hospital SAFE Email Correspondence with Hospital Email Correspondence with State Police Email Correspondence with Safe Haven Correspondence: Connecticut Alliance to End Sexual Violence Corrective Action: Staff Training 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 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, Waterbury 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: Reviewing and Responding to Allegations of Sexual Abuse states that: law enforcement will be immediately called to respond to allegations of sexual abuse (p. 1). Additionally, the policy provides a uniform evidence protocol for responding to allegations of sexual abuse and sexual harassment. · Policy: Data Collection and Review of Sexual Abuse and/or Sexual Harassment Incidents provides an overview of the review of all allegations and the expectation to follow the uniform evidence protocol. · Policy: Medical and Mental Health Care for Victims of Sexual Abuse provides guidance on the medical and mental health component when responding to allegations of sexual abuse. · Correspondence with Connecticut State Police: correspondence with Connecticut State Police confirmed that they would conduct the sexual abuse or criminal related investigations. · Email correspondence with Safe Haven provides documentation of the continued partnership for victim advocacy and emotional support services. 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. While they could identify key actions such as separating the resident, notifying a supervisor, they needed prompting to include critical steps such as securing the area, wearing gloves if touch anything, preventing the resident from showering, brushing teeth, using the bathroom and completing report. Five stated that the PREA Coordinator would handle sexual abuse investigations, one indicated that human resources would conduct the investigations, and one was unaware of who is responsible for investigations. Corrective Actions: Staff Training: Significant probing was needed in order to get the staff to explain how evidence would be carried out. Staff had a variety of responses and did not seem to be sure of what to do aside from separating individuals and notifying a supervisor. It is recommended that the facility conduct additional training with staff on the evidence protocol process.

	Ø Corrective Action Taken: Additional training was conducted. No further action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.221 (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 offers all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. o The number of forensic medical exams conducted during the past 12 months: 0 o The number of exams performed by SANEs/SAFEs during the past 12 months: 0 o The number of exams performed by a qualified medical practitioner during the past 12 months: 0 · Policy: Medical and Mental Health Care for Victims of Sexual Abuse states that “Connecticut Renaissance shall offer all victims of sexual abuse access to forensic medical examinations without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If the area hospitals do not have available SAFE or SANEs then the examination can be performed by other qualified medical practitioners” (p. 1). · MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services. · Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention

team, and community education).

· Waterbury Hospital SAFE: email correspondence with Waterbury Hospital indicates their ability to conduct the forensic examinations.

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 make 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: Medical and Mental Health Care for Victims of Sexual Abuse states that “Victims shall be referred to a victim advocate at a rape crisis center. • The agency shall obtain and maintain Memorandum of Understanding with local crisis centers and the hospitals to ensure a portal for services. Documentation of the MOU will be maintained by the PREA Coordinator. • As requested by the victim, the victim advocate, Connecticut Renaissance staff and/or other requested support may accompany the victim through the forensic medical examination process and investigatory interviews and shall provide crisis intervention, information and referrals. • A referral for treatment services shall be provided to the victim. • The Agency does not provide specialized treatment services for victims of sexual assault; victims will be referred to outside source for medical and mental health

	services (p. 1). · MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services. Email correspondence with Safe Haven provides documentation of the continued partnership for victim advocacy and emotional support services. · Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education). · The auditor reviewed the Connecticut Alliance to End Sexual Violence (Support, Advocate, Prevent) website on April 3, 2025. This is a statewide agency that operates has nine (9) alliances. The Alliance's nine member centers have provided free and confidential services to children, adolescents, and adult victims of sexual violence throughout Connecticut. Survivors can access services 24/7/365 via phone or at their local center. Each center offers counseling; support groups; accompaniments in hospital, police, and court settings; case management and support while navigating complex systems post-disclosure; and a myriad of other trauma-informed services that support healing, connection, and justice. These services are available to all survivors in Connecticut – regardless of age, sex, immigration status, race, ethnicity, nationality, sexual orientation, gender identity or expression, or religious or spiritual beliefs. There is a 24-Hour, Toll-Free Hotlines: 1-888-999-5545 (English) and 1-888-568-8332 (Espanol). On April 3, 2025, at 10:18 a.m., the auditor called Connecticut Alliance to End Sexual Violence (1-888-999-5545) to test the process. A male staff member answered and explained that if no one picks up the main office number, the call rolls over to the next available center. If it's outside their region, they forward the call based on the Connecticut Zip code. Calls are private and confidential, and each of the nine centers has a local hotline number posted. On April 3, 2025, at 10:43am, the auditor contacted the Connecticut Alliance to End Sexual Violence Spanish hotline (1-888-568-8332) to test the process. A male staff member answered the call and explained that if the caller were female, he would inform his supervisor. The call would then be forwarded to the appropriate center in the relevant region. The review of the Zero Tolerance for Detainee Sexual Abuse and Sexual Harassment Section title "Victim Support Services" has the following information: The Connecticut State Police has partnered with the Connecticut Alliance to End Sexual Violence to provide survivors of sexual abuse with emotional support services. To access these services, contact 888-999-5545 or send a letter to: Connecticut Alliance to End Sexual Violence at 96 Pitkin St., East Hartford, CT 06108. Interviews PREA Coordinator – The interviewed staff reported that the agency shall attempt to

	make a victim advocate available from a rape crisis center. The facility has a Coordinated Response Plan that specifically includes the directive to offer contact to victim advocacy services. 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: Medical and Mental Health Care for Victims of Sexual Abuse states that "Victims shall be referred to a victim advocate at a rape crisis center. • The agency shall obtain and maintain Memorandum of Understanding with local crisis centers and the hospitals to ensure a portal for services. Documentation of the MOU will be maintained by the PREA Coordinator. • As requested by the victim, the victim advocate, Connecticut Renaissance staff and/or other requested support may accompany the victim through the forensic medical examination process and investigatory interviews and shall provide crisis intervention, information and referrals. • A referral for treatment services shall be provided to the victim. • The Agency does not provide specialized treatment services for victims of sexual assault; victims will be referred to outside source for medical and mental health services (p. 1). · MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services. · Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education). Interviews PREA Coordinator – The interviewed staff reported that victims of sexual abuse shall

	receive timely access to emergency medical treatment and crisis intervention services. Upon receiving a report, CT Renaissance will promptly connect the victim to emotional support services, appropriate treatment planning, recommended services and referrals for continued care. CT Renaissance offers all victims access to forensic medical examinations without financial cost where evidentiary or medically appropriate which are performed by SAFE (Sexual Assault Forensic Examiners) where possible or other qualified medical practitioners. Victims will be referred to a victim advocate at a rape crisis center. As requested by the victim, the victim advocate, CT Renaissance staff or other requested support may accompany the victim through the forensic exam process, investigatory interviews, crisis intervention, information and referral process. The agency doesn't provide specialized treatment for sexual assault, but victims will be referred outside for medical and mental health services. 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, iff 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 Waterbury PD confirms the agency agreement to conduct sexual abuse investigations. · The auditor corresponded with the State Troopers who further reported that they conduct investigations at the community confinement sites across the state. 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 (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. It should be noted that the facility utilizes state approved sexual assault centers. 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: Reviewing and Responding to Allegations of Sexual Abuse (Reviewed 2022) Interviews: Agency Head Investigative Staff 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: Reviewing and Responding to Allegations of Sexual Abuse states that "Investigations into allegations of sexual abuse and sexual harassment shall be done so promptly, thoroughly, and objectively for all allegations including third-party and anonymous reports. Investigations shall be conducted by law enforcement for sexual abuse reports, internal reviews and investigations of reports of sexual harassment incidents will be reviewed and coordinated by the PREA Coordinator. PREA Coordinator, Program Director or designee shall contact the State Police Department to initiate a criminal investigation when appropriate. Law enforcement will take the lead role in investigations for sexual abuse and CTR staff will cooperate with such investigations and shall endeavor to remain informed about the progress of the investigation. An effort to determine whether staff actions or failures to act contributed to the abuse. Shall be documented in written reports of the review and the findings" (p. 1). · 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 will conduct the criminal investigation, and our agency will conduct the administrative investigation. All parties are immediately notified of the allegations. 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: Reviewing and Responding to Allegations of Sexual Abuse states that "Investigations into allegations of sexual abuse and sexual harassment shall be done so promptly, thoroughly, and objectively for all allegations including third-party and anonymous reports. Investigations shall be conducted by law enforcement for sexual abuse reports, internal reviews and investigations of reports of sexual harassment incidents will be reviewed and coordinated by the PREA Coordinator. PREA Coordinator, Program Director or designee shall contact the State Police Department to initiate a criminal investigation when appropriate. Law enforcement will take the lead role in investigations for sexual abuse and CTR staff will cooperate with such investigations and shall endeavor to remain informed about the progress of the investigation. An effort to determine whether staff actions or failures to act contributed to the abuse. Shall be documented in written reports of the review and the findings" (p. 1). · There were no incidents of sexual abuse or sexual harassment to review. · 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 at https://ctrenaissance.org/about/licensin-g-accreditation/prea/. 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 handled internally. 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 or made publicly available via other means at https://ctrenaissance.org/about/licensin-g-accreditation/prea/. 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: Training Requirements (Review Date: 2023) Policy: Outline of Training Requirements (Review Date: 2023) Mandated Reporter Training PPT NEO Training Prison Rape Elimination Act PREA Training Pamphlet PREA Training PPT PREA Acknowledgement Signed/Staff PREA Training Understanding (12) PREA Refresher Training (5) 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: Training Requirements policy provides the agency overview of staff training requirements. · Policy: Outline of Training Requirements: Provides a list of all training requirements for full and part time staff; based on their agency roles and responsibilities. · Mandated Reporter Training: Addresses the roles and responsibilities of Mandated Reporters · NEO Training Prison Rape Elimination Act: The PPT is comprehensive training addresses all of the training requirements of the provision. · PREA Training Pamphlet: The pamphlet serves as a comprehensive training pamphlet created by the American Probation and Parole Association on “Preventing and Responding to Corrections-Based Sexual Abuse: A Guide for Community Corrections Professionals”. · PREA Training PPT: General presentation on the PREA standards. Training Curriculum: The agency training curriculum covers all of the above-mentioned elements. The agency's training curriculum comprehensively covers all necessary topics, including the prevention, detection, reporting, and response to sexual abuse and sexual harassment. This training ensures that staff are well-equipped to uphold the rights of residents and employees to be free from abuse and retaliation. · Sample of Training Record: 12 records were reviewed for new hire staff showing the completion of PREA training. A sample of 12 training records confirmed the completion of PREA training for new hires, and interviews with randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. Interviews

	Random Sample of Staff – All of the staff interviewed confirmed that they received PREA education during onboarding/OJT training and undergo refresher training multiple times a year using the online platform Relias. This training covers policy updates, employee and resident rights, recognizing signs of sexual abuse, and reporting and response procedures. They demonstrated knowledge of how to prevent, detect, report, and respond to sexual abuse and harassment, including identifying physical harm, maintaining appropriate boundaries, and recognizing signs such as closed off, quiet, or isolated. Additionally, the staff articulated strategies to prevent inappropriate relationships with resident by avoid sharing personal information, not doing favors for resident and comply with mandated reporting laws. Staff were also able to give examples regarding residents may display anger, change behaviors, avoidance and fear as dynamics and reactions of sexual abuse and sexual harassment. Staff also reported training how to effectively, professional and respectfully speak to all residents including lesbian, gay bisexual, transgender and intersex. 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 (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. · Mandated Reporter Training: Addresses the roles and responsibilities of Mandated Reporters · NEO Training Prison Rape Elimination Act: The PPT is comprehensive training addresses all of the training requirements of the provision. · PREA Training Pamphlet: The pamphlet serves as a comprehensive training pamphlet created by the American Probation and Parole Association on “Preventing and Responding to Corrections-Based Sexual Abuse: A Guide for Community Corrections Professionals”. · PREA Training PPT: General presentation on the PREA standards. Training Curriculum: The agency training curriculum covers all of the above-mentioned

	elements. The agency's training curriculum comprehensively covers all necessary topics, including the prevention, detection, reporting, and response to sexual abuse and sexual harassment. This training ensures that staff are well-equipped to uphold the rights of residents and employees to be free from abuse and retaliation. · Sample of Training Record: 12 records were reviewed for new hire staff showing the completion of PREA training. A sample of 12 training records confirmed the completion of PREA training for new hires, and interviews with randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. 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. · Sample of Training Record: 12 records were reviewed for new hire staff showing the completion of PREA training. A sample of 12 training records confirmed the completion of PREA training for new hires, and interviews with randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. · Refresher Training: Five records were reviewed for existing staff show the completion of PREA Refresher Training. Refresher training occurs bi-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. 115.231 (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. · Training Acknowledgement: The agency ensures that employees who may have contact with residents confirm their understanding of the training received through either a signature or electronic verification. The agency changed the process to electronic and the electronic process does not have an acknowledgement. · Staff PREA Understanding Acknowledgement Signed (12). Sample of Training Record: 12 records were reviewed for new hire staff showing the completion of PREA training. A sample of 12 training records confirmed the completion of PREA training for new hires, and interviews with randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. 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: Volunteers and Interns (Review Date: 2023) Training Curriculum (Same as employees 115.231) Interviews: Volunteer(s) or Contractor(s) who may have Contact with Residents 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 Volunteers and Interns policy states that "All applicants accepted as Volunteers or Interns shall have a complete orientation and training period that includes at a minimum client rights, security and confidentiality regulations, emergency procedures, lines of communication and authority, information regarding insurance coverage, information about personal risks and liability, and all agency policies and procedures. "(p. 1). If there are volunteers or contractors, the facility will utilize the PREA training curriculum that is used for staff. · Training Curriculum (Same as employees 115.231). · There were no volunteers or contractors to review training records. 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.

· Training Curriculum (Same as employees 115.231)

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. · There were no volunteers or contractors to review training records. 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: Prison Rape Elimination Act (Review Date: 2025) Client PREA Brochure Acknowledgement (English/Spanish) Carelogic Client PREA Brochure Acknowledgement (26) PREA Brochure (English/Spanish) 12 Month Roster Resident Handbook PREA Visitor Rules Resident Transfer (1) Interviews:

	Intake Staff (1) Resident (11) 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: 116. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: o Policy: Prison Rape Elimination Act states that “During the admission process, all individuals in the custody of the Judicial Branch or Department of Correction are provided information about Connecticut Renaissance’s zero-tolerance policy along with instructions for reporting a complaint.” (p. 3). o Carelogic Client PREA Brochure Acknowledgement (26) o PREA Brochure (English/Spanish): provided to residents at intake addressing how to report sexual assault, defining sexual abuse/harassment/voyeurism; your rights, help for victims and families, defining PREA, and contact information on how to report. o 12-month roster of residents o Resident Handbook: The resident handbook provides information to residents that the they can seek assistance from staff if there is a need for language or literacy assistance. Site Review: o The auditor confirmed that the intake worker conduct the intake. The auditor participated in a mock demo with the intake worker. o The auditor evaluated how the facility provides the necessary PREA information to all residents. The intake worker conducts the intake as soon as the resident arrives. The resident was brought into the workers office, and the door was shut. o The worker proceeded to explain to the mock client the intake process and ask the residents where they were aware of PREA. The worker then explained to the resident what PREA was, how to make a report, that there was no retaliation for reporting and providing the mock resident with the PREA form. The worker went over the PREA brochure, several medical questionnaires along with a face sheet. The resident PREA policy agreement was covered and the resident signed

	acknowledgment and receipt. o The auditor observed that the information provided is at a high school reading level. The auditor inquired and staff reported that they would seek assistance from another staff if a resident spoke Spanish. If a resident had challenges with reading, they would explain all documents to the resident. The worker highlighted how to make a report in English and in Spanish. o Staff are prepared to read written information out loud, if applicable, to make accommodations for persons confined in the facility when necessary. It was further reported that they would review the packet provided by the prison to determine if there were any disabilities that would hinder their ability to deliver the information. INTERPRETATION SERVICES o The auditor evaluated the facility's process for securing interpretation services on-demand. The auditor contacted the language line and determined that the services worked properly. It should be noted that residents have their own cellphones to use as well. o Residents do not have to self-identify when using the language line. The line only requires an agency code to access interpretation services. o The services were available immediately upon call and request. o Due to the cost of accessing interpretation services, the language line has to be set up with the Director; however, residents have immediate access to multiple bilingual staff to immediately interpret the most common language of Spanish. o During informal conversations with staff, it was reported that the agency has several bilingual staff that speak Spanish. o The case managers were able to readily state that they would seek interpreter services if needed. 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.

	One resident was vague and stated that they recently provided them documentation and updated the postings on the wall. Another resident initially reported that they couldn't recall because they were upset when they arrived however later in the interview they could recall. 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: 1. · The auditor reviewed the file of the one resident that was transferred from another facility. The intake packet confirmed that the resident received PREA education consistent with any new intake. 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 in the last 12 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 Admissions and Orientation states that “the program shall provide orientation and information in a manner of which can be understood by the person served. Information shall be in formats that are accessible to those who are limited English proficient, deaf, visually, impaired and otherwise disabled as well as those how have limited reading skills. · PREA Brochure (English/Spanish): provided to residents at intake addressing how to report sexual assault, defining sexual abuse/harassment/voyeurism; your rights, help for victims and families, defining PREA, and contact information on how to report. The brochures are available in the most common languages of English and Spanish. 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. · Policy: Prison Rape Elimination Act states that “During the admission process, all individuals in the custody of the Judicial Branch or Department of Correction are provided information about Connecticut Renaissance’s zero-tolerance policy along with instructions for reporting a complaint.” (p. 3). · Carelogic Client PREA Brochure Acknowledgement (26) · PREA Brochure (English/Spanish): provided to residents at intake addressing how to report sexual assault, defining sexual abuse/harassment/voyeurism; your rights, help for victims and families, defining PREA, and contact information on how to report. · 12-month roster of 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. 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 Brochure (English/Spanish): provided to residents at intake addressing how to report sexual assault, defining sexual abuse/harassment/voyeurism; your rights, help for victims and families, defining PREA, and contact information on how to report. · Posting (Spanish/English) Audit Site Review: · During the onsite inspection the auditor observed PREA posters, resident handbooks, PREA brochures and information 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 facility requires any visitor

	to the site to sign information on the PREA Zero Tolerance Rules (uploaded). · The auditor did not observe that there was victim advocacy and emotional support services readily accessible throughout the facility. It was located in one location and staff were not actively aware of where it was located. · General information on PREA such as how to report was readily accessible. The auditor observed the following on the 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 tested 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 on how to report 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: Additional Key Information: The facility is required to display information regarding victim advocacy and emotional support services. Documentation must be provided to demonstrate that this information is readily accessible to both staff and residents, including comprehensive details of the services offered. Ø Correction Action Taken: The additional information was displayed. No further

	action is required. Resident Education: The facility must educate residents on how to access victim advocacy and emotional support services, along with detailed descriptions of these services. Ø Documentation confirming that this education has taken place must be provided. Documentation was provided. No further action is required. 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 Corrective Action Taken: The additional training was provided. No further action is required. Intake: The facility must provide documentation confirming that information about victim advocacy and emotional support services is included in the intake process. Additionally, staff must be trained to explain the scope of services offered by the designated advocacy center associated with the facility. Ø Corrective Action Taken: The facility updated the resident education at intake to include information on victim advocacy and emotional support. 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: Training Requirements (2023) Training Certificate of Completion (PREA: Investigating Sexual Abuse in a

	Confinement Setting) (1) Training Certificate (PREA Coordinators' Your Roles and Responsibilities) (1) Interviews: Investigative Staff 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 itself 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 requires 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. · Policy: Training Requirements states that "The agency PREA coordinator and any staff conducting PREA investigations will complete training in conducting sexual abuse investigations in confinement settings (NIC PREA: Investigating Sexual Abuse in a Confinement Setting or equivalent)" (p. 1). · Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) (1): the certificate provides verification of the staff completion of training. · Training Certificate (PREA Coordinators Your Roles and Responsibilities) (1): the certificate provides verification of the staff completion of training. 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: 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. 115.234 (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: · Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) · Training Certificate (Your Role Roles and Responsibilities) 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: 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. 115.234 (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 maintains documentation showing that investigators have completed the required training. The number of investigators currently employed who have completed the required training: 2. · Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) (2): the certificate provides verification of the staff completion of training. · Training Certificate (PREA Coordinators Your Roles and Responsibilities) (1): the certificate provides verification of the staff completion of training.

	· Upon further discussion, the agency PREA Coordinator reported that the second trained investigator does not conduct the PREA related investigations but is trained to handle any HR related matters. 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. 115.234 (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) Findings (By Provision): 115.235 (a). The agency ensures 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 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: · As reported in the PAQ, the agency medical staff at this facility do not conduct forensic medical exams. 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: Screening for Risk of Victimization and Abusiveness (Review Date: 2021) PREA Screening (Paper Version)-Sample PREA Screening Carelogic (26) PREA Screening Carelogic Rescreening (22) Corrective Action Documents:

	Assessments/Reassessments Interviews: Staff Responsible for Risk Screening (1) Resident Interview Questionnaire (11) 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 Screening for Risk of Victimization and Abusiveness policy states that “The PREA Screening Assessment shall be conducted with the client within 72 hours of admission” (p. 1). Audit Site Review: · During the site review the auditor observed some PREA signage in the main area of the site along with the resident housing area. 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: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this 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 Screening for Risk of Victimization and Abusiveness policy states that “The PREA Screening Assessment shall be conducted with the client within 72 hours of admission” (p. 1). · PREA Screening Risk Assessment (26) The auditor reviewed the PREA Screening Risk Assessment verifying that the risk screenings were conducted within 72 hours of the admission. 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 – These eleven residents were interviewed. All but two of the residents could recall if they were asked questions like whether you had been in jail or prison before, whether you have ever been sexually abused, whether you identify as being gay, lesbian, or bisexual, and whether you think you might be in danger of sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 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. o PREA Screening Risk Assessment (26) The auditor reviewed the PREA Screening Risk Assessment verifying that the risk screenings were conducted within 72 hours of the admission. The auditor compared the risk screening with the placement date. A random set of residents were selected from the auditor to review. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 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 (26) The auditor reviewed the PREA Screening Risk Assessment verifying that the risk screenings were conducted within 72 hours of the admission. 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 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: PREA Screening Risk Assessment: While the facility consistently utilized the PREA Screening Risk Assessment on residents upon admission to the facility, the tool did not ask if a resident identified as intersex or gender non-conforming. The facility shall update the tool and provide documentation that is being utilized with the new intakes. Ø Corrective Action Taken: The facility updated the screening tool to add the additional language for intersex and gender non-conforming. 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. 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: 92. · Policy: Screening for Risk of Victimization and Abusiveness states that “within 30 days of admission, the program will reassess the resident’s risk of victimization for abusiveness based upon any additional relevant information received by the facility since the intake screening” (p. 2).

	· PREA Risk Screening re-assessment (22). It should be noted that the auditor randomly selected assessments to review. Of the 26 randomly selected assessments, 22 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 two weeks. The reassessment is done by the case manager. Resident Interview Questionnaire – Three 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. Corrective Actions: PREA Screening Risk Assessment: While the facility consistently utilized the PREA Screening Risk Assessment on residents upon admission to the facility, the tool did not ask if a resident identified as intersex or gender non-conforming. The facility shall update the tool and provide documentation that is being utilized with the new intakes. Ø Corrective Action Taken: The facility updated the screening tool to add the additional language for intersex and gender non-conforming. Discussion: A review of 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: Screening for Risk of Victimization and Abusiveness states that “a residents 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” (p. 3). Interviews

	Staff Responsible for Risk Screening -The staff interviewed reported that reassessments occur within two weeks and that the case manager will conduct any other reassessments as deemed necessary. Resident Interview Questionnaire – Three 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. 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 (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: Screening for Risk of Victimization and Abusiveness states that "Residents may not be disciplined for refusing to answer, or for not disclosing complete information" (p. 3). 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. Discussion: A review of 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 (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 secured, 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. It was determined that the director printed a copy of all of the risk assessments and placed in the COD office for the audit. The auditor requested that the documents were removed from the COD office and placed in the director's office. 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 staff could review. PREA Coordinator: The staff interviewed reported that information is accessible only to those tasked with monitoring client safety. Information received is used from a programmatic perspective in determining service needs and ensuring the safety of the resident. We have controls in place to ensure that information is appropriately used and ensure that sensitive information is not exploited by staff or other residents. Employees, volunteers, interns or contractors found to be using sensitive

	information to the detriment of the resident will be subject to corrective action including termination. 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.

115.242	**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: Screening for Risk of Victimization and Abusiveness (Review date 2021) Facility Layout Programming Placement Transgender Resident (assessment) 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 Screening for Risk of Victimization and Abusiveness states that "Information received during the screening / evaluation process shall uphold all of CT Renaissance's standards of confidentiality. Information received shall be used from a programming and treatment perspective in determining service needs and ensuring the safety of the resident. Employees, volunteers, interns or contractors found to be using sensitive information to the detriment of the resident shall be the subject of corrective action up to and including termination" (p. 3). · The facility provided a comprehensive layout of the entire premises and the location of residents. · The auditor reviewed the risk screening for 26 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. · The facility leadership and admissions staff was able to articulate how residents' housing determination is done on a case-by-case basis; incorporating the health and safety, potential security management concerns and resident on views. The facility provided examples of current assessment where a transgender resident was housed in accordance with their safety needs and not by default based on gender identity or sex assigned at birth. The same practice is utilized for other residents who were considered vulnerable or at risk. 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. CT Renaissance uses the Screening Assessment for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) tool and clients receive this screening within 72 hours of admission. The screening tool is scored and utilized to make housing, monitoring and treatment or service decisions/recommendations. In addition, if the resident is identified as a vulnerable victim or sexually aggressive, it will be noted in the POP sheet to assist

	staff in monitoring them. Within 30, the program will be reassessed. 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: PREA Screening Risk Assessment: While the facility consistently utilized the PREA Screening Risk Assessment on residents upon admission to the facility, the tool did not ask if a resident identified as intersex or gender non-conforming. The facility shall update the tool and provide documentation that is being utilized with the new intakes. Ø Corrective Action Taken: The facility updated the screening tool to add the additional language for intersex and gender non-conforming. Discussion: A review of 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 Evaluation and the Intake Interview policy states that “Once information is gathered, a Behavioral Health Evaluation Narrative Assessment is written, which includes the interviewer's observations, a brief risk assessment, an initial treatment plan and preliminary discharge plan. The narrative is written based on the client's expectations, including their strengths, needs, abilities, attitudes, skills and interests. This assessment is conducted within specific time frames and is used in the development of the individual re-entry plan. This assessment will identify any co-occurring disabilities/disorders that should be addressed when developing the individual plan including preliminary discharge plans” (p. 2) 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:

	PREA Screening Risk Assessment: While the facility consistently utilized the PREA Screening Risk Assessment on residents upon admission to the facility, the tool did not ask if a resident identified as intersex or gender non-conforming. The facility shall update the tool and provide documentation that is being utilized with the new intakes. Ø Corrective Action Taken: The facility updated the screening tool to add the additional language for intersex and gender non-conforming. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.242 (c). 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 Screening for Risk of Victimization & Abusiveness states that “Bed placements for transgender or intersex residents shall be based on concerns for resident’s health hand safety. The transgender or intersex resident’s own view of safety needs shall be a serious consideration in making bed placements. However, the program shall not place lesbian, gay, bisexual, transgender or intersex residents in dedicated areas solely on the basis of such identification or status, unless such placement is in a dedicated area established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents. Documentation of placement considerations shall be maintained in the” (p. 3). · Transgender Assessment Packet: The auditor reviewed the assessment for the transgender resident housed at the facility. The resident utilized the information from the assessment to make decision to place the resident in a single room. 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. The agency accepts referrals to Work Release within our admission criteria

	and as per our contract with DOC. Any management or security problems would be addressed on an individual basis, in coordination with DOC, and handled accordingly, with the joint goals of ensuring safety while facilitating client access to the program. Transgender/Intersex Residents – The interviewed resident reported that staff did not ask about their safety. They also said they cannot remember what they were asked at intake because they were upset about some other things. The resident did report that they were placed in a single 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 (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. 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 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 – The interviewed resident reported that staff did not ask about their safety. They also said they cannot remember what they were asked at intake because they were upset about some other things. 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 Screening for Risk of Victimization & Abusiveness states that "Transgender and intersex residents shall be given the opportunity to shower separately from other residents" (p. 3). · 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 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 – The interviewed resident reported that they were not placed in special housing however they were provided their own room. They are allowed to shower separately from other 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. 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:

	· Documentation of housing assignments of residents identified to be lesbian, gay, bisexual, transgender, or intersex for compliance with the standard. There was one transgender resident housed at the facility. The resident was placed in a single room; however, the room was not separated from other rooms in the facility. 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 – The interviewed resident reported they were placed in a single room; however, there is no special housing. 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.

115.251	**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: Reporting of Sexual Abuse or Harassment (Review Date: 2025) Orientation Checklist with Supervisor PREA Visitor Rules

	Interviews: Random Sample of Staff (7) Resident Interview Questionnaire (11) 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: Reporting of Sexual Abuse or Harassment states that “Staff shall report to their next level Supervisor and the agency’s PREA Coordinator any knowledge or suspicion of sexual abuse and/or harassment against a client / resident by another client/resident, employee, volunteer, intern or contractor. Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents should also be reported. • Staff shall utilize the PREA Incident report form on behalf of the client / resident to initiate a response by the PREA Coordinator. • Staff may make such reports in a private manner of which they are comfortable. Such reports of sexual abuse, harassment, known retaliation or concerns of neglect on the part of another staff, volunteer, intern or contractor may be submitted in writing or verbally to the PREA Coordinator and may be done so anonymously” (p. 1). Audit Site Review: Signage Clarity and Accessibility: Upon review, the auditor determined that the signage is on a high school reading level; according to the Flesh-Kincaid reading level. PREA brochures and posters were available in both English and Spanish. These materials provide information on the right to report, actions to take if one is abused, zero tolerance policies, and contact details for reporting sexual abuse or harassment. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake.

	Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Other PREA Signage: In addition to signage being placed in areas typically utilized by residents, PREA posters on how to report were placed in staffing areas. The signage was posted on the staff boards in the administrative area. Testing Internal Reporting Methods for Confined Persons · Internal Reporting: o The auditor assessed the internal reporting methods by contacting the phone numbers listed on the facility's posters. It was confirmed that residents can call the hotline to make a report, and if an allegation is made, the Connecticut State Police will assign to an investigator and will notify the facility to initiate an investigation. · Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. The grievance box is located in the common area. o Informal conversations with residents confirmed that they have access to writing materials, and they can write a grievance. · Electronic Reporting: o The facility reported that the residents have access to computers and could make a report on the agency website. It should also be noted that the residents have their own cell phones. · Verbal Reporting: o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member, and they feel comfortable approaching trusted staff privately. o Staff consistently reported that residents can verbally report allegations at any time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay. Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom) · Incoming/Outgoing Mail: o The auditor observed that residents have ready access to paper and pencils for

writing letters. The outgoing mail process is as follows:

§ Residents write a letter, place it in an envelope and it is left in an area retrieved every day. The COD staff will verify that the resident is still at the facility. The residents are required to open mail in front of the staff. Staff reported that they do not read the mail.

§ Residents also have an ability to mail using the public mail system.

Record Storage

· Risk Screening Process:

o The risk screening and other assessment tools are securely stored in an electronic case management system.

o Additional documentation on the residents in paper files is kept in a locked file cabinet and room in the program. The room had limited staff access.

o The records room is locked and secured, limited to the leadership staff. Cameras are placed in the hallways accessible to the record rooms.

· Access Control:

o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted.

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 notifying staff, calling the number on the poster or writing a grievance as well as use their own cellphones.

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:

Discussion: A review of 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: Reporting of Sexual Abuse or Harassment states that “Clients / Residents may make verbal or written reports of sexual abuse or harassment to their Clinician, Program Director, PREA Coordinator, Director of Quality Improvement or any other employee they feel comfortable in reporting sexual abuse or sexual harassment; Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and, staff neglect or violation of responsibilities that may have contributed to such incidents. • Staff must allow the client / resident a private area to report their concerns and make their report. Staff must accept both verbal and/or written incident reports. If the client / resident is willing to make a written report, the PREA incident report form should be utilized. If not, the staff person taking the report can write the report” (p. 1). · PREA Brochure: The PREA Brochure (115.333), provides residents with multiple ways to make a report. Site Review Signage Clarity and Accessibility: Upon review, the auditor determined that the signage is on a high school reading level; according to the Flesh-Kincaid reading level. PREA brochures and posters were available in both English and Spanish. These materials provide information on the right to report, actions to take if one is abused, zero tolerance policies, and contact details for reporting sexual abuse or harassment. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas.

	Other PREA Signage: In addition to signage being placed in areas typically utilized by residents, PREA posters on how to report were placed in staffing areas. The signage was posted on the staff boards in the administrative area. Testing Internal Reporting Methods for Confined Persons · Internal Reporting: o The auditor assessed the internal reporting methods by contacting the phone numbers listed on the facility's posters. It was confirmed that residents can call the hotline to make a report, and if an allegation is made, the Connecticut State Police will assign to an investigator and will notify the facility to initiate an investigation. · Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. The grievance box is located in the common area. o Informal conversations with residents confirmed that they have access to writing materials, and they can write a grievance. · Electronic Reporting: o The facility reported that the residents have access to computers and could make a report on the agency website. It should also be noted that the residents have their own cell phones. · Verbal Reporting: o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member, and they feel comfortable approaching trusted staff privately. o Staff consistently reported that residents can verbally report allegations at any time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay. Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom) · Incoming/Outgoing Mail: o The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows: § Residents write a letter, place it in an envelope and it is left in an area retrieved every day. The COD staff will verify that the resident is still at the facility. The residents are required to open mail in front of the staff. Staff reported that they do not read the mail. § Residents also have an ability to mail using the public mail system.

Record Storage

· Risk Screening Process:

o The risk screening and other assessment tools are securely stored in an electronic case management system.

o Additional documentation on the residents in paper files is kept in a locked file cabinet and room in the program. The room had limited staff access.

o The records room is locked and secured, limited to the leadership staff. Cameras are placed in the hallways accessible to the record rooms.

· Access Control:

o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted.

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. The crisis centers will forward reports of sexual abuse and sexual harassment to agency officials. Staff will accept anonymous and third-party reports, in addition to verbal or written reports.

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 but two 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: Reporting of Sexual Abuse or Harassment states that “Clients / Residents may make verbal or written reports of sexual abuse or harassment to their Clinician, Program Director, PREA Coordinator, Director of Quality Improvement or any other employee they feel comfortable in reporting sexual abuse or sexual harassment; Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and, staff neglect or violation of responsibilities that may have contributed to such incidents. • Staff must allow the client / resident a private area to report their concerns and make their report. Staff must accept both verbal and/or written incident reports. If the client / resident is willing to make a written report, the PREA incident report form should be utilized. If not, the staff person taking the report can write the report” (p. 1).

· PREA Brochure: The PREA Brochure (115.333), provides residents with multiple ways to make a report.

· The PREA Visitor form provides information to visitors about the agency zero tolerance policy and requirements to report.

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. All seven staff interviewed stated they would immediately notify a supervisor upon receiving a report and follow proper procedures to ensure the allegation is addressed promptly.

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: Reporting of Sexual Abuse or Harassment states that “Staff shall report to their next level Supervisor and the agency’s PREA Coordinator any knowledge or suspicion of sexual abuse and/or harassment against a client / resident by another client/resident, employee, volunteer, intern or contractor. Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents should also be reported. • Staff shall utilize the PREA Incident report form on behalf of the client / resident to initiate a response by the PREA Coordinator. • Staff may make such reports in a private manner of which they are comfortable. Such reports of sexual abuse, harassment, known retaliation or concerns of neglect on the part of another staff, volunteer, intern or contractor may be submitted in writing or verbally to the PREA Coordinator and may be done so anonymously” (p. 1). · 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 notify supervisor, Program Director, email PREA hotline, write incident report or 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) Corrective Action: Training 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. Corrective Actions: Education: While the agency does not currently employ the grievance process to address allegations, it was determined that individuals have the option to utilize the grievance form to file a complaint. Upon filing, the complaint is promptly forwarded to the investigation process. During the onsite assessment, the auditor could not thoroughly examine the grievance logbook as the grievances were not hosted in a single place like a grievance logbook. The agency shall retrain the director on how to maintain a grievance logbook.

	Ø Corrective Action Taken: The facility has provided the required training. No further is action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.252 (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 otherwise 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 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. (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: Policy updates were made to ensure compliance with the provision. Ø Corrective Action Taken: The resident handbook was updated to clearly articulate

	the process. No further action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 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: Reporting of Sexual Abuse and/or Harassment (Review Date: 2025) MOU: Safe Haven of Greater Waterbury Safe Haven of Greater Waterbury Sexual Assault Services Safe Haven Information Sheet PREA Brochure (English/Spanish) Carelogic Client PREA Brochure Acknowledgement (26) Email Correspondence with Safe Haven Correspondence: Connecticut Alliance to End Sexual Violence Corrective Action Staff Training Resident Education Correspondences With Safe Haven Interviews:

	Resident Interview Questionnaire – (11) Site Review 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: Reporting of Sexual Abuse and/or Harassment states that “Clients / Residents may contact Safe Haven, 29 Central Ave in Waterbury, CT at (203) 753 3613 (for sexual assault services) or The Center for Family Justice located at 753 Fairfield Ave., Bridgeport, 203-334-6154. The crisis centers shall forward reports of sexual abuse and sexual harassment to agency officials. Clients may remain anonymous if they desire. Client/residents also may call 911 for an immediate report to local and CT State Police. Connecticut Renaissance will provide victims with access to external victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and phone numbers of such community resources. The programs shall enable communication between residents and such community resources in as confidential manner as possible.” (p. 2). · Carelogic Client PREA Brochure Acknowledgement (26) · PREA Brochure (English/Spanish): provided to residents at intake states “Victims of sexual harassment and/or sexual abuse are offered advocacy services through Safe Haven, 29 Central Ave, Waterbury, CT. at (203) 753-3613 (hotline) or at The Center for Family Justice in Bridgeport, CT at (203) 333-2233 (hotline)”. · MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services. · Email correspondence with Safe Haven provides documentation of the

continued partnership for victim advocacy and emotional support services.

· Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education). The auditor reviewed the Connecticut Alliance to End Sexual Violence (Support, Advocate, Prevent) website on April 3, 2025. This is a statewide agency that operates has nine (9) alliances. The Alliance's nine member centers have provided free and confidential services to children, adolescents, and adult victims of sexual violence throughout Connecticut. Survivors can access services 24/7/365 via phone or at their local center. Each center offers counseling; support groups; accompaniments in hospital, police, and court settings; case management and support while navigating complex systems post-disclosure; and a myriad of other trauma-informed services that support healing, connection, and justice.

· These services are available to all survivors in Connecticut – regardless of age, sex, immigration status, race, ethnicity, nationality, sexual orientation, gender identity or expression, or religious or spiritual beliefs. There is a 24-Hour, Toll-Free Hotlines: 1-888-999-5545 (English) and 1-888-568-8332 (Espanol).

On April 3, 2025, at 10:18 a.m., the auditor called Connecticut Alliance to End Sexual Violence (1-888-999-5545) to test the process. A male staff member answered and explained that if no one picks up the main office number, the call rolls over to the next available center. If it's outside their region, they forward the call based on the Connecticut Zip code. Calls are private and confidential, and each of the nine centers has a local hotline number posted.

On April 3, 2025, at 10:43am, the auditor contacted the Connecticut Alliance to End Sexual Violence Spanish hotline (1-888-568-8332) to test the process. A male staff member answered the call and explained that if the caller were female, he would inform his supervisor. The call would then be forwarded to the appropriate center in the relevant region.

The review of the Zero Tolerance for Detainee Sexual Abuse and Sexual Harassment Section title "Victim Support Services" has the following information: The Connecticut State Police has partnered with the Connecticut Alliance to End Sexual Violence to provide survivors of sexual abuse with emotional support services. To access these services, contact 888-999-5545 or send a letter to: Connecticut Alliance to End Sexual Violence at 96 Pitkin St., East Hartford, CT 06108.

Site Review:

· The auditor observed that there was limited to no signage regarding victim advocacy and emotional support services posted in the facility. The auditor located one posting near the front entry way; however, staff were unable to readily state where the signage was located.

· During informal conversation with staff and residents, neither were well informed about victim advocacy and emotional supportive services.

· The auditor tested all of the phone numbers provided to make a report. All numbers were active and working. The external reporting source provided the auditor with an overview of how allegations were handled that came through their hotline.

· Outside Emotional Support via Phone

The auditor tested the phone lines by calling the outside emotional support service provider. The telephone number was working, and the information was provided in English and Spanish. It should be noted that the Spanish number was not working. The phone number is local and there is a toll-free number provided. A live person was spoken to and explained the various services offered at the facility.

· All persons at the site have regular access to phones to contact the outside emotional support service provider(s) and have reasonable accommodations.

· Residents have access to their own cellphones; therefore, they can have unmonitored correspondence with outside emotional support services confidentially.

Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom)

· Incoming/Outgoing Mail:

· The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows:

· Residents write a letter, place it in an envelope and it is left in an area retrieved every day. The COD staff will verify that the resident is still at the facility. The residents are required to open mail in front of the staff. Staff reported that they do not read the mail.

· Residents also have an ability to mail using the public mail system.

Interviews

Resident Interview Questionnaire – Three of the eleven interviewed residents reported that they were aware of outside services that deal with sexual abuse if needed. None of them could name a specific place. The others said in general that they know there are services, just can’t 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. Ø Documentation confirming that this education has taken place must be provided. 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 Corrective Action Taken: The additional training was provided. No further action is required. Resident Education/Intake: The agency shall develop a process to incorporate educating residents at intake on emotional support and victim advocacy services. This can be done by adding an additional handout our adding to the resident handbook and the staff overview the handbook. Ø Corrective Action Taken: The facility updated the resident education at intake to include information on victim advocacy and emotional support. Postings: There was one posting of victim advocacy and emotional support posted in the facility near the entry of the facility. The facility shall provide more postings in the common areas, residential housing areas and visitation area. Ø Additional information was posted in the facility. Spanish Telephone Number: The facility shall call and verify the correct number for Spanish calls and update the brochure as 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. 115.253 (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: Reporting of Sexual Abuse and/or Harassment states that “Clients / Residents may contact Safe Haven, 29 Central Ave in Waterbury, CT at (203) 753 3613 (for sexual assault services) or The Center for Family Justice located at 753 Fairfield Ave., Bridgeport, 203-334-6154. The crisis centers shall forward reports of sexual abuse and sexual harassment to agency officials. Clients may remain anonymous if they desire. Client/residents also may call 911 for an immediate report to local and CT State Police. Connecticut Renaissance will provide victims with access to external victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and phone numbers of such community resources. The programs shall enable communication between residents and such community resources in as confidential manner as possible.” (p. 2). · PREA Brochure (English/Spanish): provided to residents at intake states “Victims of sexual harassment and/or sexual abuse are offered advocacy services through Safe Haven, 29 Central Ave, Waterbury, CT. at (203) 753-3613 (hotline) or at The Center for Family Justice in Bridgeport, CT at (203) 333-2233 (hotline)”. · 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 eleven interviewed residents reported that they were aware of outside services that deal with sexual abuse if needed. None of them could name a specific place. The others said in general that they know there are services, just can’t 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. Corrective Actions: Resident Handbook: The auditor recommends that the facility update the handbook to include details of what victim advocacy and emotional support entails and provide documentation to the auditor. Additionally, the handbook shall address any limitations to confidentiality.

	Ø Corrective Action Taken: The facility updated the resident education at intake to include information on victim advocacy and emotional support. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.253 (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. · Policy: Reporting of Sexual Abuse and/or Harassment states that “The agency shall enter into memoranda of understanding or other agreements with community service providers that are able to provide clients/ residents with confidential, emotional support services related to sexual abuse. Connecticut Renaissance will maintain copies of such agreements or documentation showing attempts to enter into such agreements” (p. 2). · MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services. · Email correspondence with Safe Haven provides documentation of the continued partnership for victim advocacy and emotional support services. · Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education). 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: Reporting of Sexual Abuse and/or Harassment Website: PREA | CT Renaissance PREA Brochure (English/Spanish) Prison Rape Elimination Act Client Sign Off 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 provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The agency or facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. · Policy: Reporting of Sexual Abuse and/or Harassment states that “Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates shall be permitted to assist clients / 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. • If a third party files such a request on behalf of a resident, the facility may request, as a condition of processing the request that the alleged victim agree to have the request filed on his / her behalf. If the resident declines to have the request processed on his / her behalf, Connecticut Renaissance shall document such decision” (p. 2).

	· PREA Brochure (English/Spanish): provided to residents at intake provides various methods for reports of allegations of sexual abuse and sexual harassment. · Prison Rape Elimination Act Client Sign Off · Website PREA | CT Renaissance: Provides information to the public on third party reporting. Audit Site Review: o During the site review, the auditor meticulously observed facility signage to assess its readability and accessibility. o The clarity and comprehensibility of signage language, especially concerning services like emotional support and external reporting, were thoroughly examined. o 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. o 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. o The accuracy and consistency of information across facility signage were carefully evaluated during the site review. o 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. o 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. o The auditor conducted tests on the third-party reporting system either before, during, or after the onsite visit to ensure its functionality and accessibility. o A test third-party report was completed and submitted through the same method available to the public, typically via the facility's website. o 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. o 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.

	o 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. Discussion: A review of 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.

115.261	**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: Reporting of Sexual Abuse and/or Harassment Sample of Reports to Investigators (1) 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: Reporting of Sexual Abuse and/or Harassment states that “Connecticut Renaissance requires all staff to report immediately and initiate a coordinated response to any knowledge, suspicion, or information regarding an incident of sexual abuse or harassment that may have taken place against a client by another client, employee, volunteer, intern or contractor. Residents / Clients shall be encouraged and provided a safe means of reporting such abuse. Anyone who reports an allegation of sexual abuse or harassment may do so without fear of reprisal” (p. 1). The policy further states that “Staff shall report to their next level Supervisor and the agency’s PREA Coordinator any knowledge or suspicion of sexual abuse and/or harassment against a client / resident by another client/resident, employee, volunteer, intern or contractor. Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents should also be reported” (p. 1).

Audit Site Review: Staff Reporting Method Review:

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

o 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.

o 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.

o 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. All seven staff also reported that they understand they are prohibited from retaliating against resident or staff that reported sexual abuse or sexual harassment. The various ways staff indicated that they would report included, but was not limited to: · Report to supervisor · PREA Coordinator 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 Reporting of Sexual Abuse and/or Harassment states that “Staff may make such reports in a private manner of which they are comfortable. Such reports of sexual abuse, harassment, known retaliation or concerns of neglect on the part of another staff, volunteer, intern or contractor may be submitted in writing or verbally to the PREA Coordinator and may be done so anonymously. • Apart from reporting to designated supervisors or the PREA Coordinator staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, review and other security and management decisions. • Unless otherwise precluded by Federal, State or local law, agency staff shall be required to report sexual abuse and must inform client / residents of their duty to report, and the limitations of confidentiality at the initiation of services.” (p. 1).

	Audit 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. - Furthermore, the electronic safeguards for information stored electronically, such as risk screening information, were examined to ascertain the measures implemented for securing 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 there responsibility is to report immediately to the supervisor. All seven staff also reported that they understand they are prohibited from retaliating against resident or staff that reported sexual abuse or sexual harassment. The various ways staff indicated that they would report included, but was not limited to: · Report to supervisor · 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. 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 sit 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 identified allegations of sexual abuse.

Interviews

Director or Designee: The interviewed staff reported that all allegations of sexual

	abuse and sexual harassment are received and reported to 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.

115.262	**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: Reviewing and Responding to Allegations of Sexual Abuse and/or Sexual Harassment Interviews: Agency Head Director or Designee Random Sample of Staff (7) Findings (By Provision): 115.262 (a). When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident. 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 immediate, please explain in the comments section. N/A. · Policy: Reviewing and Responding to Allegations of Sexual Abuse and/or Sexual Harassment states that “If the resident is identified from the screening as a vulnerable victim (VV) or as sexually aggressive (SA) these designations will be noted on the POP sheet to assist the staff in monitoring them” (p. 2). 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 possibly staying in a single room. 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, separate involved parties and getting further guidance from the supervisor. Corrective Actions: Policy: The policy provided does not address imminent risk and responding to a what an agency will do if it learns that a resident is subject to a substantial risk of imminent sexual abuse. · Corrective Action Taken: The policy was updated to include the above-mentioned language. No further action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

	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: Reporting of Sexual Abuse and/or Harassment Report to another confinement site Interviews: Agency head Director or designee Findings (By Provision): 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 Reporting of Sexual Abuse and/or Harassment policy states that "Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Director that received the allegation shall notify the head of the facility or the appropriate office of the agency where the alleged abuse occurred" (p. 2). 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 Reporting of Sexual Abuse and/or Harassment policy states that "Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Director that received the allegation shall notify the head of the facility or the appropriate office of the agency where the alleged abuse occurred" (p. 2). The policy further states that "Such notification must be done so as soon as possible, but no later than 72 hours after receiving the allegation" (p. 2). 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 Reporting of Sexual Abuse and/or Harassment policy states that "Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Director that received the allegation shall notify the head of the facility or the appropriate office of the agency where the alleged abuse occurred. • Such notification must be done so as soon as possible, but no later than 72 hours after receiving the allegation. • The Program Director will apprise the Connecticut Renaissance PREA Coordinator of such allegations and collaborate with the PREA Coordinator in terms of ensuring appropriate notifications. • The PREA Coordinator will maintain documentation of such reports and communication with other organizations" (p. 2). 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 Reporting of Sexual Abuse and/or Harassment policy states that "If Connecticut Renaissance receives a report from another organization of an allegation of sexual abuse that supposedly occurred at a Connecticut Renaissance facility. Connecticut Renaissance shall follow up and initiate a review of the report" (p. 3). 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 and HR 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.

	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: Reviewing and Responding to Allegations of Sexual Abuse 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: Reviewing and Responding to Allegations of Sexual Abuse, serves as the agency first responder policy. The policy provides a detailed description of the procedures for staff first responder duties. 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 involved parties to a safe location, notifying their supervisor immediately or law enforcement, and ensuring that no one contaminated evidence. The staff struggled to articulate how to handle the evidence. Residents who Reported a Sexual Abuse – There were no identified residents who reported a sexual abuse. Corrective Actions: Staff Training: Additional training for staff on how to handle evidence. Ø Corrective Action Taken: The facility provided additional training to staff. 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. 115.264 (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: Reviewing and Responding to Allegations of Sexual Abuse, serves as the agency first responder policy. The policy provides a detailed description of the procedures for staff first responder duties. · Policy: Reviewing and Responding to Allegations of Sexual Abuse, indicates that all staff are considered first responders. 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) Central Coordinated Response 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. · 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 practioners, investigators, and facility leadership. 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. 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: Prison Rape Elimination Act (PREA) Policy Interviews: Agency Head Director or Designee Designated Staff Member Charged with Monitoring Retaliation (or Director if nonavailable) - 1

	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. · Policy: The Prison Rape Elimination Act (PREA) policy provides guidance on the protection of staff and residents who report sexual abuse. More specifically it states that “Any employee, contractor, intern, volunteer, or individual in the custody of the Judicial Branch or Department of Correction who reports an incident of sexual abuse or sexual harassment or cooperates in a sexual abuse or sexual harassment investigation must not be retaliated against. Any complaint of retaliation by an employee, contractor, intern, volunteer, or individual in the custody of the Judicial Branch or Department of Correction will be reported and investigated in accordance with the procedures and instruction provided in this policy. Any individual who is found to have been in violation of this policy will be subject to appropriate disciplinary action and/or referred to the State Police for criminal investigation. • Connecticut Renaissance will take necessary measures to ensure protection of those reporting or assisting in the investigation of sexual abuse or sexual harassment. Such measures may include changing of residential assignment or staff assignment or offering emotional support services. • The agency’s PREA Coordinator and Human Resources Department will monitor the conduct and treatment of those employees and individuals in the custody of the Judicial Branch or Department of Correction and will remedy any discovered retaliation” (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. 115.267 (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.

· Policy: The Prison Rape Elimination Act (PREA) policy provides guidance on the protection of staff and residents who report sexual abuse. More specifically it states that “Any employee, contractor, intern, volunteer, or individual in the custody of the Judicial Branch or Department of Correction who reports an incident of sexual abuse or sexual harassment or cooperates in a sexual abuse or sexual harassment investigation must not be retaliated against. Any complaint of retaliation by an employee, contractor, intern, volunteer, or individual in the custody of the Judicial Branch or Department of Correction will be reported and investigated in accordance with the procedures and instruction provided in this policy. Any individual who is found to have been in violation of this policy will be subject to appropriate disciplinary action and/or referred to the State Police for criminal investigation. • Connecticut Renaissance will take necessary measures to ensure protection of those reporting or assisting in the investigation of sexual abuse or sexual harassment. Such measures may include changing of residential assignment or staff assignment or offering emotional support services. • The agency’s PREA Coordinator and Human Resources Department will monitor the conduct and treatment of those employees and individuals in the custody of the Judicial Branch or Department of Correction and will remedy any discovered retaliation” (p. 6).

Interviews

Agency Head – The interviewed agency head reported that they would take protective measures of retaliation is identified. Such measures may include increased monitoring, possibly place in a single room, and increased camera monitoring.

Director or Designee/Designated Staff Member Charged with Monitor Retaliation – 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. As the program director my role is to report any retaliation to PC, and she is also the grievance person. Speak to staff (if staff are involved). Do an incident report. If staff being retaliated will ask staff to leave. I will separate residents and depending on situation we would also notify the parole officer and possibly state police.

	Residents who Reported a Sexual Abuse – There were no identified residents who reported sexual abuse. Corrective Actions: Staff Training: the facility director has limited knowledge on how monitoring for retaliation should take place. The agency PREA Coordinator shall training the facility director on various ways to monitor for retaliation and how to document monitoring Ø Corrective Action Taken: The facility has provided the required training. No further action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.267 (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. · Policy: The Prison Rape Elimination Act (PREA) Policy states that “For at least 90 days following a report of sexual abuse, Connecticut Renaissance shall monitor the conduct and treatment of clients / 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. 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. 7). Interviews Director or Designee/ 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 won't 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: Staff Training: the facility director has limited knowledge on how monitoring for retaliation should take place. The agency PREA Coordinator shall training the facility director on various ways to monitor for retaliation and how to document monitoring and how monitoring should occur. Ø Corrective Action Taken: The facility has provided the required training. No further action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.267 (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 identified allegations of sexual abuse. Interviews Designated Staff Member Charged with Monitoring Retaliation (or Director if nonavailable) - The interviewed staff reported that they will monitor for changes in behavior. 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 won't come out of their rooms, eat, or take medication. 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 identified allegations of sexual abuse. Interviews Agency Head – The interviewed agency head reported that they would take protective measures of retaliation is identified. Such measures may include increased monitoring, possibly place in a single room, and increased camera monitoring. Director or Designee – The interviewed staff reported that they would monitor for changes in behavior, by having them come to the office, call the PREA Coordinator and the Parole Office to get additional guidance. 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A the 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.

115.271	**Criminal and administrative agency investigations**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act (PREA) Policy Interviews: PREA Coordinator Investigative Staff 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 Prison Rape Elimination Act (PREA) Policy states that “All internal administrative investigations of allegations of sexual harassment will be conducted promptly, thoroughly and objectively. The PREA Coordinator shall initiate and coordinate the investigation process. The Human Resources Department shall serve as the reviewing authority for all allegations of, sexual harassment, or retaliation involving a Connecticut Renaissance employee and an individual in the custody of the Judicial Branch or Department of Correction.” (pp. 5-6). · 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 handled by the same standards. Anonymous or third-party reports follow the same protocols. Responses to all reports include keeping the victim safe from retaliation and reporting on the progress of the 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 (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: · 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. · Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) and Training Certificate (Your Roles and Responsibilities) can be located in standard 115.234. Interviews Investigative Staff – The interviewed staff stated that they have completed the NIC specialized training. The National Institute of Corrections courses called PREA: Investigating Sexual Abuse in a Confinement Setting and PREA: Coordinators' Roles and Responsibilities 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. 115.271 (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 when an allegation is made, first responders utilize the Coordinated Response Plan to determine immediate actions including separation of the victim and suspect, immediate first aid and preservation of evidence. Criminal investigations are conducted by the State Police who would be contacted by first responders as part of the coordinated response. Administrative investigations begin when the PREA Coordinator is notified. Once confirming that the investigation is Administrative in nature, the context and details of the allegation are clarified via formal and informal interviews, review of any evidence, and review of records that may have a bearing on the case.

The PREA Coordinator initiates and coordinates the investigation process, which takes into account physical, testimonial and documentary evidence gathered from interviews, records, electronic equipment and any relevant source. The internal administrative investigation will include whether the alleged incident of sexual harassment, or retaliation was the result of employee misconduct or negligence. The investigation is documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The Human Resources Department serves as the reviewing authority for all allegations of, sexual harassment, or retaliation involving a CT Renaissance employee, following the full HR investigative process.

Also, as the PREA Coordinator, I am responsible for gathering testimonial and documentary evidence, which may include but isn't limited to formal and informal interviews, documentation of physical evidence, or electronic data and records that may be pertinent to the situation. Evidence collection in criminal investigations is handled by the State Police, while the agency's coordinated response includes preservation of 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.

115.271 (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. Interviews Investigative Staff – The interviewed staff reported that all information and referral for prosecution would be handled by outside law enforcement. CT Renaissance does not conduct criminal investigations. Upon report of any possible criminal conduct or prosecutable crime, State Police are immediately contacted. State Police would confer with prosecutors in the handling of allegations that appears to be criminals. 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 not be assessed based on an individual's status as a client or staff person. Reasoning behind credibility assessments is documented as part of the written investigative report. A resident who alleges sexual abuse will never be required to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation. 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:

· Policy: The Prison Rape Elimination Act (PREA) Policy states that “The internal administrative investigation will include whether the alleged incident of sexual harassment, or retaliation was the result of employee misconduct or negligence. • The investigation 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.” (p. 6).

· 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 must:

The physical storage of PREA investigations is stored in a locked file cabinet in the Directors office and offsite in the PREA Coordinators office.
During informal conversation with staff, it was determined that direct care staff do not know or have access to the investigations.

Interviews

Investigative Staff – The interviewed staff reported that internal administrative investigation always includes whether the alleged incident of sexual harassment, or retaliation was the result of employee misconduct or negligence. The determination is based on the available evidence and is subject to a review process by which recommendations are made to prevent future instances of staff misconduct or negligence. The investigation 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.

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 the State Police would maintain documentation of their criminal investigations. CT Renaissance would make every effort to remain in communication with the State Police and to obtain a copy of their final 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. 115.271 (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. · There were no reported criminal investigations. Interviews Investigative Staff – The interviewed staff reported that State Police handles 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. · Policy: The Prison Rape Elimination Act states that “The agency shall retain all written reports referenced in this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years” (p. 6). 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 (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: · There were no reported criminal investigations. 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: · The reported allegations of sexual abuse or sexual harassment. 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 handled 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. 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.

115.272	**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: Prison Rape Elimination Act (PREA) Policy Interviews: Investigative Staff 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: · Policy: Prison Rape Elimination Act provides guidance on the administrative investigation process and the standards imposed. “The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual harassment are substantiated.” (p. 6). 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: Reviewing and Responding to Allegations of Sexual Abuse 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 Prison Rape Elimination Act states that "Following a review into a client/resident's allegation of sexual abuse suffered while receiving services in a CT Renaissance facility, the PREA Coordinator shall inform the client / resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded." (p. 2). 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 in a CT Renaissance facility, the PREA Coordinator informs the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. 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.

	· 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: Reviewing and Responding to Allegations of Sexual abuse. states that "following a review into a client/resident's allegation of sexual abuse suffered while receiving services in a CT Renaissance facility, the PREA Coordinator shall inform the client / resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The client shall be informed (unless the alleged sexual abuse was determined to be unfounded) whenever: The staff member is no longer assigned within the residents unit; The staff member is no longer employed at the facility; CT Renaissance learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility" (p. 2).

	· 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: Reviewing and Responding to Sexual Abuse states that “Following a clients allegation that he/she has been sexually abused by another resident, CT Renaissance shall subsequently inform the alleged victim whenever: o CT Renaissance learns that the alleged abuser has been indicted 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” (2). · 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: Reviewing and Responding to Sexual Abuse states that “All notifications or attempted notification shall be documented and maintained in a file by the PREA Coordinator.” (p. 2). 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: Reviewing and Responding to Allegations of Sexual Abuse 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: · 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. · Compliance Determination: · Policy: Reviewing and Responding to Allegations of Sexual Abuse · states that “Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies” (p. 2). 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: Reviewing and Responding to Allegations of Sexual Abuse states that "Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse" (p. 2). 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. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted. 115.276 (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: Reviewing and Responding to Allegations of Sexual Abuse states that "Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member' disciplinary history and the sanctions imposed for comparable offenses by other staff with similar histories" (p. 2). 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: Reviewing and Responding to Allegations of Sexual Abuse states that "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" (p. 2) 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: Reviewing and Responding to Allegations of Sexual Abuse 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: Reviewing and Responding to Allegations of Sexual Abuse states that “Any contractor or volunteer who engages in sexual abuse shall be 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” (p. 2). 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: Reviewing and Responding to Allegations of Sexual Abuse states that "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". 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. 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: Reviewing and Responding to Allegations of Sexual Abuse 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 that have occurred at the facility: 0. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that 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 disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. Policy: Reviewing and Responding to Allegations of Sexual Abuse states that “CT Renaissance may impose disciplinary sanctions on a client / resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact” (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. 115.278 (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. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that “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 a review does not establish evidence sufficient to substantiate the allegation” (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. 115.278 (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 Medical and Mental Health Care for Victims of Sexual Abuse (Review Date: 2025) Corrective Action: Training on Evidence Protection (May 9, 2024) 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 Medical and Mental Health Care for Victims of Sexual Abuse policy states that “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” (p. 1). 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:

· Policy: The Medical and Mental Health Care for Victims of Sexual Abuse policy states that “Upon receiving a report of alleged sexual abuse or sexual harassment, Connecticut Renaissance shall promptly connect the victim with emotional support services including a mental health evaluation and, as appropriate treatment planning, recommended treatment services and referrals for continued care following discharge” (p. 1).

Interviews

Security Staff and Non-Security Staff First Responders – All of the direct care staff are first responders. The interviewed staff were responsible for the agency’s first responder protocol, which included how to protect the evidence, separate the involved parties, and report to supervisor/ management for further action.

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 (c). 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.

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.

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: Discussion: A review of 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 Medical and Mental Health Care for Victims of Sexual Abuse policy states that “Connecticut Renaissance shall offer all victims of sexual abuse access to forensic medical examinations without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If the area hospitals do not have available SAFE or SANEs then the examination can be performed by other qualified medical practitioners” (p. 1). 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: The Medical and Mental Health Care for Victims of Sexual Abuse 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 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 Medical and Mental Health Care for Victims of Sexual Abuse policy states that “Upon receiving a report of alleged sexual abuse or sexual harassment, Connecticut Renaissance shall promptly connect the victim with emotional support services including a mental health evaluation and, as appropriate treatment planning, recommended treatment services and referrals for continued care following discharge. • Connecticut Renaissance shall offer all victims of sexual abuse access to forensic medical examinations without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If the area hospitals do not have available SAFE or SANEs then the examination can be performed by other qualified medical practitioners” (p. 1). 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 a sexual abuse during the audit cycle. 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. Corrective Actions: Policy needs to be updated to meet the requirements of the provision. Ø Corrective Action Taken: The policy was updated to reflect the above-mentioned language. No further action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.283 (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 Medical and Mental Health Care for Victims of Sexual Abuse policy states that “A referral for treatment services shall be provided to the victim. • The Agency does not provide specialized treatment services for victims of sexual assault; victims will be referred to outside source for medical and mental health services” (p. 1).

	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: Data Collection and Review of Sexual Abuse Incidents (Review Date: 2025) PREA Incident Report (sample) PREA Incident Review (sample) PREA Annual Report (2024) Interviews: Director PREA Coordinator Incident Review Team (2) 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 Data Collection and Review of Sexual Abuse Incidents Policy states, "Connecticut Renaissance shall conduct a sexual abuse incident review at the conclusion of every sexual abuse report and administrative investigation of sexual harassment allegations, including where the allegation has not been substantiated, unless the allegation has been unfounded" (p. 1).

· PREA Incident Review sample was provided, showing how the agency documents sexual abuse incident reviews.

· 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 ordinarily conducts 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 Data Collection and Review of Sexual Abuse Incidents Policy states, "The review shall occur within 30 days of the conclusion of the investigation." (p. 1).

	· PREA Incident Review sample was provided, showing how the agency documents sexual abuse incident reviews. · 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 Data Collection and Review of Sexual Abuse Incidents Policy states, “The review team shall include the Chief Operating Officer, PREA Coordinator, Program Director, Department Director and Direct Care staff and medical or mental health practitioners.” (p. 1). · PREA Incident Review sample was provided, showing how the agency documents sexual abuse incident reviews. · 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 they have not had to participate in an incident review. Corrective Actions: Staff Training: While the facility director has not had to participate in an incident review, they are also not aware of their requirements and responsibilities if an

	incident review were to take place. The auditor is recommended that the PREA Coordinator conduct training with the director to provide them with an understanding of their responsibilities. Ø Corrective Action Taken: The facility has provided the required training. No further action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.286 (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 Data Collection and Review of Sexual Abuse Incidents Policy states “The review team shall: o Consider whether the allegation or administrative review indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; o 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; o Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; o Assess the adequacy of staffing levels in that area during different shifts; o Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; o Prepare a report of its findings, including but not necessarily limited to determinations made by the review team

	along with any recommendations for improvement. The report shall be submitted to the Chief Executive Officer, Board of Directors and PREA Coordinator. o Connecticut Renaissance shall implement recommendations for improvement or document reasons for not doing so." (p. 1). Interviews Director – The interviewed director struggled to articulate the requirements of conducting an incident review. 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. The PREA Coordinator is involved both in the development of the report, and in ensuring that recommendations are implemented and followed, be it changes to facility, policy and procedure, education or other areas. The agency's quality and safety processes also ensure that such changes are successfully implemented and maintained. 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. During the investigation as well as during the review of the incident, the area in the facility where the incident allegedly occurred is assessed to determine whether any barriers in the facility could potentially enable 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. 115.286 (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. · PREA Incident Review sample was provided, showing how the agency documents sexual abuse incident reviews. · The PREA Incident Review form documents incidents of sexual abuse or harassment involving individuals under the custody of the Judicial Branch or Department of Corrections. This form collects essential information to facilitate the investigation of such allegations. 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: Data Collection and Review of Sexual Abuse Incidents (Review Date: 2025) 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 Data Collection and Review of Sexual Abuse Incidents Policy states that “Connecticut Renaissance shall collect accurate, uniform data for every allegation of sexual abuse at facilities. A set of standards shall be established to track occurrences and their circumstances” (p. 1). 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 Data Collection and Review of Sexual Abuse Incidents Policy states that “The incident-based data collected shall include at a minimum the data

	necessary to answer all questions from the most recent version of the survey of Sexual Violence conducted by the Department of Justice" (p. 1). 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 Data Collection and Review of Sexual Abuse Incidents Policy states that "Connecticut Renaissance shall maintain, review and collect data as needed from all available incident-based documents including reports, investigation files and sexual abuse incident reviews" (p. 2). 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: Data Collection and Review of Sexual Abuse Incidents (Review Date: 2025) Website https://ctrenaissance.org/about/licensing-accreditation/prea/ Annual Report (2024) 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 Data Collection and Review of Sexual Abuse Incidents policy states that “Connecticut Renaissance shall review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. Including; • Identifying problem areas; • Taking corrective action on an ongoing basis; • Preparing an annual report of its findings and corrective actions for each facility as well as the agency as a whole. 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” (p. 2). · The annual report can be located on the agency website at: https://ctrenaissance.org/about/licensing-accreditation/prea/ · 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. The PREA Coordinator conducts the incident review by going over all of the steps and determining other steps or actions that can be taken. If change is needed, we would incorporate into meetings with directors and policy changes. PREA Coordinator – The interviewed staff reported that the data and annual reports are reviewed by CT Renaissance leadership and made available through the agency website. The annual report outlines findings and corrective action for the facility as well as 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. 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 annual report can be located on the agency website at: https://ctrenaissance.org/about/licensing-accreditation/prea/ 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. · Annual Report (2024): the annual report was reviewed and found to have provided data and corrective actions for prior years. · The annual report can be located on the agency website at: https://ctrenaissance.org/about/licensing-accreditation/prea/ 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 Data Collection and Review of Sexual Abuse Incidents policy states that “Data and associated annual reports shall be reviewed by Connecticut Renaissances’ Leadership and made available through the agency’s website. Connecticut Renaissance 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” (p. 2). · 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. CT Renaissance 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: Data Collection and Review of Sexual Abuse Incidents (Review Date: 2025) Website: https://ctrenaissance.org/about/licensing-accreditation/prea/ 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 Data Collection and Review of Sexual Abuse Incidents policy states that “Data and associated reports on sexual abuse and sexual harassment shall be securely retained” (p. 2). 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 report is reviewed by senior leadership. All critical data and documents are stored on a secure network server which is regularly backed up. CT Renaissance conducts internal quality reviews of incidents, data and corrective action to ensure the health and safety of our clients and to prevent further incidents of sexual abuse or harassment. Data and annual reports are reviewed by CT Renaissance leadership and made available through the agency website. The annual report outlines findings and corrective action for the facility as well as 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. 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. · Policy: The Data Collection and Review of Sexual Abuse Incidents policy states that “Connecticut Renaissance shall post annually all aggregated sexual abuse data from its programs readily available to the public through its website” (p. 2). · The annual report can be located on the agency website at: https://ctrenaissance.org/about/licensing-accreditation/prea/ 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 Data Collection and Review of Sexual Abuse Incidents policy states that “Prior to making data available, all personal identifiers shall be removed” (p. 2). 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 Data Collection and Review of Sexual Abuse Incidents policy states that “Connecticut Renaissance shall maintain sexual abuse data collected for at least 10 years after the date of the initial collection unless Federal, State or local law requires otherwise” (p. 2). Interviews: PREA Coordinator: Prior to making the data available on the website, all personal identifiers are removed. CT Renaissance 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: 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 facility posts its PREA Audit reports on the Agency website. The reports are available for review at https://ctrenaissance.org/about/licensing-accreditation/prea/. There is a link to the final PREA reports. The facility is compliant with the intent of the standard. 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.

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.)	yes
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.)	yes
	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.)	yes
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	yes

	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)).	yes
	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)).	yes
	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)).	yes
	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)).	yes
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).)	yes
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).)	yes
	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).)	yes
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.)	no
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the	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.)	yes