PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: December 2, 2016

Auditor Information			
Auditor name: Peter Plant			
Address: 6302 Benjamin Road, Suite 400, Tampa, FL 33634			
Email: pplant@prodigy.net			
Telephone number: (813) 784-4478			
Date of facility visit: March 15, 2016			
Facility Information			
Facility name: Milestone Women's Program			
Facility physical address: 391 Pomfret St., Putnam, CT 06260			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: (860) 753-4446			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☒Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Heather Gates			
Number of staff assigned to the facility in the last 12 months: 30			
Designed facility capacity: 16			
Current population of facility: 13			
Facility security levels/inmate custody levels: None			
Age range of the population: 18-65			
Name of PREA Compliance Manager: Siobhan Feliciano		**Title:** Clinical Program Director	
Email address: SFeliciano@CHRHealth.org		**Telephone number:** (860) 753-4481	
Agency Information			
Name of agency: Community Health Resources			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 995 Day Hill Road, Windsor CT 06095			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: (860) 731-5522			
Agency Chief Executive Officer			
Name: Heather Gates		**Title:** President & CEO	
Email address: hgates@CHRHealth.org		**Telephone number:** (860) 697-3320	
Agency-Wide PREA Coordinator			
Name: Winnie Neville		**Title:** Service Director	
Email address:		**Telephone number:**	

AUDIT FINDINGS

NARRATIVE

Milestone is a 30 day intensive residential treatment center located in Putnam, Connecticut and is designed to accommodate and treat women with a history of substance abuse, trauma and mental health issues. Their comprehensive services are recovery-oriented, gender-responsive and trauma-informed. Milestone offers individual and group counseling, case management and aftercare planning services. Treatment is individualized and centered around healing and wellness, essential to moving towards employment, housing and family stability. Milestone is part of CHR's Center of Excellence for Women/Women and Children located at its Putnam campus. Services include

• Individual and Group Counseling - These sessions advance the goals of individualized treatment plans for women, addressing addiction and trauma. Groups focus on coping skills, anger management, relapse prevention and recovery planning.

• Family-Centered Interventions - We help facilitate interventions that address all members in the family and include efforts to improve relationships with significant others, including; partners, parents, siblings, children and caretakers. Family interventions are an important part of the woman's preparation for long-term recovery.

• Life Skills Activities - Activities include; health education and development of self-care plans, health promoting lifestyle interventions, personal care and life skills, employment skills, parenting support and improving family relationships.

• After-Care Planning - A major focus starting at the time of admission to the program.

It is important to note that this facility is not a correctional, nor confinement facility. It has sixteen treatment beds, only two of which are used for correctional system referrals. These two beds are funded by the Connecticut Judicial Branch, Court Support Services Division (CSSD). The PREA Resource Center has provided guidance that any community facility that is not primarily used for the confinement of residents in the adult criminal system is not covered by the community confinement facility standards. CSSD, however, has taken the position that any facility with which it contracts must have a PREA Audit, regardless of the number of beds under contract. This agency is therefore contractually obligated to adopt and comply with the PREA Community Confinement Standards and to undergo a PREA Audit. As the agency and facility have just begun to develop and implement policies, procedures, and practices, it was decided that the facility would immediately initiate the audit process and enter into corrective action to meet the requirement of its contract with CSSD.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Milestone Program is a 16 bed, all female, residential substance abuse and mental health treatment program located in Putnam, CT. Putnam is a small, wooded, rural community of approximately 10,000 residents located in the far Northeast corner of the state, in an area referred to as "the quiet corner" of CT. As part of Community Health Resources (CHR) the building the Milestone Program resides in also contains two other programs: an 8 bed residential woman and child program and a small outpatient (approximately 160 clients) methadone program.

The building itself is an updated old farm house, also on property are a dining hall and 2 small maintenance sheds. The lot the building is on is heavily wooded, save for a few green spaces close to the building the residential clients can use for smoking, walking, or relaxing during program break times.

The Milestone program itself is physically divided between the first floor and finished basement level of the building. At the entry area to the unit from the first floor, there is a laundry room located on your left, on your right in an emergency exit and a staircase that leads to the basement level of the program. There is a door in front of you that is the entry to the first floor unit. Both floors of the program have the same set up - one long hallway with bedrooms, bathrooms, a staff office and common living room directly off of this main hall. Four of the bedrooms are single occupancy, 6 are double occupancy. Each hall has a fire exit at the end.

The upstairs unit has 6 doors along the hallway on your right is a bathroom, 2 double bedrooms, then another bathroom, then two single bedrooms. On your left going down the hall is a double bedroom, an exit to the back yard/dining hall, the staff office, living room, and finally a double bedroom. As you enter the downstairs portion of the unit, on your right are two bathrooms, a large living room, a double bedroom, then a single bedroom. On your left is a laundry room, a staff office, a group room, a single bedroom, then finally a double bedroom.

SUMMARY OF AUDIT FINDINGS

The agency and facility successfully completed a comprehensive corrective action plan.

Number of standards exceeded: 0

Number of standards met: 30

Number of standards not met: 0

Number of standards not applicable: 9

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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.

The facility has a general PREA Policy, MIL 1.5, that states that "CHP has zero tolerance for all forms of client on client, staff on client, or client on staff sexual abuse or sexual harassment;" however, the Policy does not contain any definitions of terms that mirror the PREA law. It does include how it will implement the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

The agency has designated the Services Director as the PREA Coordinator and the Clinical Program Director at the facility as the PREA Compliance Manager. Both report they have the time and authority to develop, implement, and oversee agency and facility efforts to comply with the PREA Standards at the facility; however, neither could be located in the organization's organizational charts.

CORRECTIVE ACTIONS REQUIRED: The facility's/agency's PREA Policy needs to include the specific PREA definitions, relating to sexual abuse and sexual harassment. The agency's organizational chart needs to include the PREA Coordinator and the facility's PREA Compliance Manager in its structure.

CORRECTIVE ACTIONS TAKEN: The agency created a specific and comprehensive PREA policy (MIL 1.21) for the Milestone facility. It clearly states that the agency has a zero tolerance for any acts of sexual abuse, assault, misconduct or harassment. Sexual activity between staff, volunteers or contracted personnel and clients, as well as between client and client is prohibited and subject to administrative and disciplinary sanctions. CHR staff shall take prudent measures to ensure the safety of both client and staff. All employees, contractors, volunteers and client shall have a clear understanding that a sexual relationship with any staff member is strictly prohibited and is a serious breach of employee conduct. The policy also has a list of definitions that are consistent with the standards. The revised organizational chart reflects the PREA Coordinator and Compliance Manager in its structure.

Standard 115.212 Contracting with other entities for the confinement of residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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.

This Standard is not applicable. The agency and facility are not public agencies and do not contract for the confinement of its residents. The facility receives funding from the Connecticut Judicial Branch, Court Support Services Division, for the provision of two treatment beds at the facility. The contract with CSSD requires the facility to comply with PREA.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The facility does not have a staffing plan that meets the requirements of the Standard.

CORRECTIVE ACTION REQUIRED: The facility must develop and implement a staffing plan that meets the requirements of the Standard.

CORRECTIVE ACTIONS TAKEN: The facility developed a Staffing Plan that meets the requirements of the standard.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The facility states that it does not conduct cross-gender strip searches nor cross-gender visual body cavity searches under any circumstances. The facility also states that it enables residents to shower, perform bodily functions, and change clothing, without any staff observing them, and does require male staff to announce their presence when entering an area where female residents may be showering, performing bodily functions, or changing clothing; however, the facility does not have a written policy and procedures that states this.

CORRECTIVE ACTION REQUIRED: The facility must develop and implement policy and procedures that meet the requirements of the Standard.

CORRECTIVE ACTIONS TAKEN: The facility has revised Policy MIL 1.21 to state that the program does not conduct cross-gender strip searches, nor cross-gender visual body cavity searches, under any circumstances. The program enables residents to shower, perform bodily functions, and change clothing, without any staff observing them. All searches of person will be conducted by female staff. Staff of the opposite sex shall announce their presence when entering the sleeping areas or an area where clients are likely to be showering, performing bodily functions, or changing clothing.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The agency has a policy, GCC 4.4, that specifically addresses interpretative services for individual with limited English proficiency (LEP) or who are deaf or hearing impaired. The purpose of the policy is to ensure that individuals with LEP or who are deaf and/or hearing impaired have equal access and equal opportunity to participate in the agency's and facility's services, activities, and programs. This policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance forms.

Reception staff are required to use the "I Speak" cards, created by the Bureau of Justice Assistance and the Ohio Office of Criminal Justice Services, to identify the preferred language of individuals seeking services. Additionally, staff are to be familiar in the use of the Telecommunications Relay Service to provide equal access to individuals who are deaf and/or hard of hearing. If the individual becomes a client of the agency, the language used to communicate with the client is kept on record. Staff must make use of a qualified interpreter, as requested by the client. The agency's Human Resources Department is responsible for maintaining a current and accurate list of multilingual staff, including name, phone number, and the languages they speak fluently. Staff must be certified by the agency as fluent in a language before being placed on this list. Staff not certified as fluent in the required language are never to be used to translate for a client in a clinical setting. If no certified staff member is available to interpret for an individual with LEP, staff will make use of a contracted qualified interpreter and/or telephonic interpreter language service, as appropriate. This service will be provided at no additional cost to the individual with LEP.

Although it is common for individuals with LEP to request that a family member or friend act as a translator, it is the policy of the agency not to use family or friends for interpretation of clinical services or other confidential information; however, the policy does not currently the prohibition of residents as interpreters or resident readers.

CORRECTIVE ACTION REQUIRED: Policy GCC 4.4 needs to be revised to prohibit the use of residents as interpreters or resident readers.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 has been revised to prohibit the use of residents as interpreters or resident readers.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Agency policy GAP 2.5 addresses background checks for any individual who receives an offer of employment (permanent or temporary), a student internship, or a volunteer assignment; however, it does not address background checks for contractors who may have contact with residents. The agency does not currently include civil or administrative adjudications in its hiring and promotion decisions, but is reviewing the method used by the Connecticut Judicial Branch CSSD in this regard. The policy includes a number of exclusionary factors with respect to hiring, but does not address sexual harassment incidents with

respect to hiring and promoting staff or enlisting the services of any contractor who may have contact with residents.

The policy contains an extensive list of agencies it contacts during the background screening process, but does not appear to include contacting all prior institutional employers to determine whether an applicant for employment resigned during a pending investigation of an allegation of sexual abuse.

The agency policy states that it conducts criminal history checks, DCF protective services screenings, and county criminal history checks every two years for all employees, student interns, temporary services workers and volunteers, which exceeds the requirement of the Standard; however, it does not conduct background checks at least every five years for contractors who may have contact with residents.

The policy states that all employees, students interns and volunteers are required to be truthful, regarding and criminal history, on any employment or other application; however, it does not clearly state that any material omission or provision of materially false information, are grounds for termination. The policy also does not state that it will provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon request by an institutional employer for whom the former employee has applied to work.

CORRECTIVE ACTIONS REQUIRED: Agency policy needs to be revised to include background checks for contractors who may have contact with residents. The agency needs to address including civil or administrative adjudications in its hiring and promotion decisions in a manner the same as or similar to how the Connecticut Judicial Branch CSSD meets this requirement. The agency needs to revise their policy to ensure that sexual harassment incidents are considered with respect to hiring and promoting staff or enlisting the services of any contractor who may have contact with residents. The policy must be revised to include contacting all prior institutional employers to determine whether an applicant for employment resigned during a pending investigation of an allegation of sexual abuse. The policy needs to be revised to more clearly state that any material omission or provision of materially false information, are grounds for termination, and that it will provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon request by an institutional employer for whom the former employee has applied to work.

CORRECTIVE ACTIONS TAKEN:

The agency revised its policy to require background checks for contractors who may have contact with residents. The agency also revised its policy to include civil or administrative adjudications in its hiring and promotion decisions, as well as incidents of sexual harassment for both staff and contractors who may have contact with residents. The reference check form was revised to include a section asking a prior institutional employer whether it is aware of any substantiated allegations of sexual abuse or any resignations of the applicant during a pending investigation of sexual abuse. The policy was also revised to require that background checks be conducted at least every five years for contractors who may have contact with residents.

Agency policy was revised to include contacting all prior institutional employers to determine whether an applicant for employment resigned during a pending investigation of an allegation of sexual abuse. It was also revised to include that, consistent with state law, it will provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon request by an institutional employer for whom the former employee has applied to work. Further, it was revised to clearly state that any material omission or provision of materially false information, are grounds for termination.

The agency created a facility specific (i.e., Milestone) form that applicants for positions at that facility must complete that includes the three questions required under s. 115.217. The form also gives notice to the applicant that knowingly making any misstatements of facts subjects the applicant to disqualification or dismissal.

The agency revised its Internal Job Posting Application form to include the PREA disclosures required by the standard. This form also advises an internal job posting applicant that any false information, misrepresentation, or concealment of facts is sufficient grounds for immediate discharge from employment.

Standard 115.218 Upgrades to facilities and technologies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

This Standard is not applicable. The facility has not made any substantial expansion or modifications or updated any video system subsequent to August 20, 2012.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The facility does not conduct any investigations of allegations of sexual abuse. This is done by local law enforcement agencies, including the State Police, which uses a uniform evidence protocol that meets the requirement of the Standard. The facility has entered into a Memorandum of Agreement with the Sexual Assault Crisis Center of Eastern Connecticut that addresses the requirements of the Standard. It is detailed as to how treatment and advocacy services are to be delivered at no cost to the residents.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Agency policy GAP 1.16 addresses incident and accident reporting policies and procedures. It includes a process for referring allegations of sexual abuse to state Department of Mental Health and Addiction Services, but does not include any process for reporting such allegations to law enforcement. The policy includes an incident category of "Other" that arguably could include an allegation of sexual harassment, but that is not clearly stated. This policy is not currently posted on the agency's website.

CORRECTIVE ACTIONS REQUIRED: The policy needs to be revised to ensure that all allegations of sexual abuse and sexual harassment are to be reported to law enforcement and state administrative agencies.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 has been revised to meet all elements of this standard.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The agency's PREA training for all employees who have contact with residents is comprehensive and includes all the required elements of the Standard and is tailored to the gender of the residents at the facility. All current employees have been trained, documentation of which is maintained at the facility.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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No documentation was provided that volunteers and contractors have received any training on PREA.

CORRECTIVE ACTION REQUIRED: The facility must provide documentation that all volunteers and contractors who may have contact with residents have received the appropriate level of PREA training.

CORRECTIVE ACTIONS TAKEN: The agency clarified that it does not use volunteers at the facility. Documentation of training contractors at the facility on PREA was provided.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Agency policy GCC 1.2 addresses notification of client rights and grievance procedure, and agency policy MIL 1.4 addresses the admission process; however, neither policy addresses resident education, regarding PREA.

CORRECTIVE ACTIONS REQUIRED: The facility must develop a comprehensive PREA education for residents that meets the requirements of the Standard. This includes developing formats for residents with limited English proficiency, deaf/hard of hearing, visually impaired, and those who have limited reading skills. All residents must be provided this education as soon as the materials are completed. The facility shall also ensure that key information is continuously and readily available to residents through posters, handbooks, and other written formats.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 has been revised to meet all of the elements of this standard.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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This Standard is not applicable. The facility does not conduct investigations of sexual abuse allegations.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The facility's medical and mental health staff have completed the specialized training developed by the National Institute of Corrections. Documentation is on file at the facility. These staff also received the general PREA training for all staff.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Agency policy GCC 1.5 addresses the intake process for adult services (i.e., this facility). It specifically includes procedures for assessments, but does not specifically address risk screening for sexual victimization or abusiveness, nor does it specify a time frame for conducting the screening. The facility has developed such an assessment tool, which is objective; however, the instructions state that staff are to assess for possible victimization or possible sexual predatory behavior, but not both. This tool is used to inform residential services, including room assignments, security checks, and level of supervision. Since the set length of stay at the facility is 30 days, it would be rare, if ever, that a reassessment of risk would occur. The policy is silent on whether residents are required to answer risk screening questions, but given the nature of this treatment program, serving a predominantly non-criminal system involved population, it is unlikely that any disciplinary actions would be taken.

Agency policy PHI 4.0 addresses the confidentiality of client information. The policy has detailed controls over access and use of client records, including the risk screening tool. Agency policy PHI 4.5 addresses the security of records and states that access to client records is done on a need-to-know basis.

CORRECTIVE ACTIONS REQUIRED: The agency's and facility's intake and risk screening policies and procedures must be revised to meet the requirements of the Standard. Staff who are responsible for conducting risk screening must be trained on the revised procedures.

CORRECTIVE ACTIONS TAKEN: The facility developed a PREA-specific Sexual Victimization or Abusiveness Tool that meets the requirements of the standard. Policy MIL 1.4 has been revised to require that all risk screening must be conducted within 72 hours of the resident's admission. Documentation of training of staff on the use of the Toll was provided.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The risk screening tool used at the facility is currently used to inform individualized residential services, including room assignments, security checks, and level of supervision, etc. This will continue once the tool is revised to meet the requirements of 115.241. The intake assessment process includes discussions with the incoming resident, regarding their safety needs. All residents are provided the opportunity to shower privately

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Residents are informed that they have a variety of ways they can privately report allegations of sexual abuse and sexual harassment. There are no impediments to communications between residents and others, including relatives and law

enforcement agencies. They are also made aware of the services of the Sexual Assault Crisis Center of Eastern Connecticut and both staff and residents are provided contact information. Residents are Also informed that they have the right to file a complaint with the Joint Commission on Accreditation for Healthcare Organizations and are given contact information for this agency.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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This Standard is not applicable. The facility does not have any administrative procedures to address residence grievances, regarding sexual abuse. Residents are free to report such allegations to staff, family members, and outside agencies.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Residents have free access to contact the Sexual Assault Crisis Center of Eastern Connecticut, with whom the facility has an MOA, or any other agency they choose, for that matter. There are no impediments to communication, and communication is not monitored. As mandatory reporters under state law, all staff must report any knowledge of or allegations of sexual abuse.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Residents have free access to contact the Sexual Assault Crisis Center of Eastern Connecticut, with whom the facility has an MOA, who in turn can make a third-party report, any family member or friend, or any other agency they choose, for that

matter. There are no impediments to communication, and communication is not monitored.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard; however, the agency's staff PREA training includes discussions of staff and agency reporting duties.

CORRECTIVE ACTION REQUIRED: The agency or facility must develop a policy that meets the requirements of this Standard.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 was revised and meets all of the elements of this standard.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Agency policy GCC 3.5 addresses supervisory review of clients at risk to self or others. This policy is very detailed and requires that any resident who presents with risk to self or others or who may be at risk of harm must be evaluated and an appropriate protective intervention taken.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

This Standard is not applicable. This facility is not a confinement facility.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTIONS REQUIRED: The facility must develop first responder procedures and train staff on their first responder duties.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 has been revised to include a specific set of first responder duties that are in compliance with this standard. Documentation of staff training was provided.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTION REQUIRED: The facility must develop a coordinated response plan and train staff on the plan, including each staff's respective duties.

CORRECTIVE ACTIONS TAKEN: The facility developed a coordinated response plan that is in compliance with the standard. Documentation of staff training was provided.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

This Standard is not applicable. The facility is not a party to any collective bargaining agreement.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Agency policy PHI 3.6 addresses retaliation and states that no resident shall be subject to any intimidation, threats, reprisals, coercion, discrimination or other retaliatory actions for filing a complaint or allegation. The Facility Director is charged with monitoring retaliation. The policy does not state any protection measures available or to be taken in the case of retaliation, nor does it include residents who cooperate with sexual abuse and sexual harassment investigations. [NOTE: the facility is a fixed 30-day length of stay; therefore, the 90 day monitoring requirement does not apply.)

CORRECTIVE ACTIONS REQUIRED: The policy needs to be revised to include protection measures available or to be taken in the case of retaliation and for residents who cooperate with sexual abuse and sexual harassment investigations.

CORRECTIVE ACTIONS TAKEN: Policy PHI 3.6 was revised to further explain that residents shall not be subject to any retaliatory actions for exercising their rights and lists protection measures available or to be taken in such instances.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

This Standard is not applicable. The facility does not conduct any form of criminal or administrative investigations.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

This Standard is not applicable. The facility does not make determinations, regarding sexual abuse or sexual harassment allegations.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTIONS REQUIRED: The facility must develop a policy that meets the requirements of this Standard.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 has been revised to state that at the conclusion of any law enforcement investigation where a sexual abuse incident has been reported, the victim should be notified that the investigation is concluded, either by the investigating law enforcement agency or through a victim services agency officer or representative. The program shall inform the client as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The requirements of subs. (c) and (d) of this standard are now included in the policy revision.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTIONS REQUIRED: The facility must develop a policy that meets the requirements of this standard.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 has been revised to include a statement that staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. The revision now includes the requirements of subs. (b), (c), and (d).

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTIONS REQUIRED: The facility must develop a policy that meets the requirements of this standard.

CORRECTIVE ACTIONS TAKEN: It was clarified that the facility does not use volunteers. Policy MIL 1.21 was revised to meet the requirements of this standard.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

This Standard is not applicable. The facility does not impose sanctions on its residents.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The facility has an MOU with a local hospital where resident victims of sexual abuse can receive services at no cost to the resident.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

One of the core services at this facility is aftercare planning after the 30-day residential treatment stay, which includes any ongoing medical and mental health care needed.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTIONS REQUIRED: The facility must develop a policy that meets the requirements of this Standard.

CORRECTIVE ACTIONS TAKEN: The facility revised Policy GAP 1.16 and developed a detailed PREA Sexual Abuse Incident Review form that meets the requirements of the standard.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTIONS REQUIRED: The facility must develop a policy that meets the requirements of this Standard.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 was revised to meet the requirements of this standard.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTIONS REQUIRED: The facility must develop a policy that meets the requirements of this Standard.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 was revised to meet the requirements of this standard.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

No documentation was provided for this Standard.

CORRECTIVE ACTIONS REQUIRED: The facility must develop a policy that meets the requirements of this Standard.

CORRECTIVE ACTIONS TAKEN: Policy MIL 1.21 was revised to meet the requirements of this standard.

AUDITOR CERTIFICATION

I certify that:

☒ 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, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Peter Plant — April 14, 2016

Auditor Signature — Date