Prison Rape Elimination Act (PREA) Audit Report
Community Confinement Facilities

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: 1-29-21 ☐ **N/A**
If no Interim Audit Report, select N/A
Date of Final Audit Report: 2/15/21

Auditor Information

Name: Jack Fitzgerald	**Email:** jffitzgerald@snet.net
Company Name: DX Consultants LLC	
Mailing Address: PO Box 55372	**City, State, Zip:** St. Petersburg FL 33732
Telephone: 203-694-4241	**Date of Facility Visit:** Dec 12/13-14, 2020

Agency Information

Name of Agency: Community Health Resources			
Governing Authority or Parent Agency *(If Applicable)*: Click or tap here to enter text.			
Physical Address: 2 Waterside Crossing		**City, State, Zip:** Windsor, CT 06095	
Mailing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: chrhealth.org			

Agency Chief Executive Officer

Name: Heather Gates	
Email: hgates@chrhealth.org	**Telephone:** (860) 697-3320

Agency-Wide PREA Coordinator

Name: Renata Chase

REAL LIFE. REAL HOPE.™

Email: rchase@chrhealth.org	**Telephone:** (860) 697-3328
PREA Coordinator Reports to: Angela Rizzolo	**Number of Compliance Managers who report to the PREA Coordinator:** 2

Facility Information

Name of Facility: Milestone

Physical Address: 931 Pomfret Street	**City, State, Zip:** Putnam CT 06260
Mailing Address (if different from above): Click or tap here to enter text.	**City, State, Zip:** Click or tap here to enter text.

The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: Click or tap here to enter text.

Has the facility been accredited within the past 3 years? ☒ Yes ☐ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA
☐ NCCHC
☐ CALEA
☒ Other (please name or describe: Joint Commission
☐ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
The facility undergoes internal audits of community correctional practices.

Facility Director

Name: Jennifer Doutre	
Email: jdoutre@chrhealth.org	**Telephone:** 860-730-8971

Facility PREA Compliance Manager

Name: Jennifer Doutre	
Email: jdoutre@chrhealth.org	**Telephone:** 860-730-8971

Facility Health Service Administrator ☐ N/A

Name: Laurie D'Aquila

Email: ld'aquila@chrhealth.org	**Telephone:** 860-301-1186

Facility Characteristics

Designated Facility Capacity:	16
Current Population of Facility:	7
Average daily population for the past 12 months:	13
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☒ Females ☐ Males ☐ Both Females and Males
Age range of population:	18-61+
Average length of stay or time under supervision	24 days
Facility security levels/resident custody levels	Community- treatment

Number of residents admitted to facility during the past 12 months	184
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	180
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	0
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☒ Yes ☒ No

Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☒ N/A 2 of 16 drug treatment beds contracted with Judicial Branch

Number of staff currently employed by the facility who may have contact with residents:	13
Number of staff hired by the facility during the past 12 months who may have contact with residents:	10
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	2
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	1
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	2
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	2
Number of single resident cells, rooms, or other enclosures:	4
Number of multiple occupancy cells, rooms, or other enclosures:	6
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No

Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☒ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	2
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☐ Facility investigators ☒ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text. ☐ N/A

Audit Narrative (including Audit Methodology)

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work completed during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Prison Rape Elimination Act (PREA) audit of the Community Health Resources (CHR) Milestone facility in Putnam, CT, took place on December 14 and 15, 2020. The audit was conducted by Mr. Jack Fitzgerald of DX Consultants LLC of St Petersburg, FL. Mr. Fitzgerald is a United States Department of Justice dually certified PREA Auditor. Milestone is one of Community Health Resources adult residential treatment programs. Clients of the program are voluntary participants in the 28-day substance abuse program. The program is required to undergo a PREA Audit as part of the contract with the Connecticut Judicial Branch, which funds two of the sixteen beds

The Auditor and Community Health Resources began discussions on Milestone PREA Audit's potential dates in June of 2020. The facility was previously audited four years earlier in 2016. The program is a short term 16-bed drug treatment facility. The facility has two beds funded by the Connecticut Judicial Branch, which requires PREA audits completed at such facilities. The DX Consultants provided an Audit Notice in two languages to the facility. The Facility Administrator posted the notice in English and Spanish, the two most common languages spoken at Milestone. The Auditor was provided with a picture of the postings up six weeks before the audit's planned site visit. The notice provides residents with information about the audit, how to contact the Auditor, and the mail's confidential nature. The notice did not result in any confidential communication from staff, residents, or other interested parties. The Auditor received a flash drive containing files supporting the Pre-Audit Tool information in November of 2020. During the Pre-Audit phase, the Auditor worked with CHR's, Jennifer Doutre, the Service Director of Adult Services. Information was exchanged through emails, video meetings, and phone contact to provide clarity of the information supplied. These interactions allowed the Auditor to request additional information to support compliance. The Auditor provided to CHR, during the Pre-Audit phase, a review of information submitted with questions on information provided or request for additional information to support compliance. Information was provided to the Auditor in advance of the site visit with other documents provided during the site visit. The Auditor provided the agency with a tentative idea of the audit day during a video call, including approximate times on-site and the list of targeted populations that would need to be identified. The Auditor encouraged the agency to use the information on-line about the audit process to work with staff, so they had an increased level of comfort to what the audit process was and what to expect. The Auditor also was able to review the previous PREA Audit report, a Joint Commission Audit report, and a Department of Mental Health and Addiction Services site visit report in preparing for the audit.

The Auditor arrived in Putnam on December 13th. The Auditor arrived at the facility at 7:45 am and was greeted by Justine Poudrette, the Residential Supervisor for Milestone. After signing in and performing COVID safety measures, the Auditor was escorted to a second floor conference room. This space would serve as the private interview space for the Auditor while on site. The room was the primary workspace for the Auditor during the audit, which allowed for appropriate social distancing. The Auditor, staff, and residents all wore masks throughout the day. Like all individuals in the environment, the Auditor underwent daily temperature monitoring consistent with CDC guidelines for institutional

settings. Supervisor Poudrette provided the Auditor with a tour of the facility, consisting of two buildings a dining hall for the residents of Milestone and CHR's Women's and Children treatment program. The main building contains two residential programs and an outpatient methadone program.
After the tour with Supervisor Poudrette, an entrance meeting occurred with Service Director Doutre and Clinical Program Director Lori Bergeron. The Auditor thanked the facility for their work to prepare the Pre-Audit tool and supporting documentation. The Auditor then explains his background and experience in auditing, the audit's goals, and what to expect throughout the two full-day process. The Auditor reviewed the tentative schedule of tours, interviews, supporting documentation verifications and that he expected to be on-site for 17 to 20 hours over the two days. The Auditor was on-site for a total of 19 hours in the two days (Day 1 7:45a-6:00p, Day 2 6:45a-3:30p), allowing for observation of staff and resident interactions across the three shifts. The Auditor finished the meeting by reviewing the fairness of the process, the reason for the targeted interviews, and how the Auditor formulates conclusions in determining compliance. The Auditor received the current population roster for the facility, which included four residents. The Auditor worked with the Service Director to identify the key staff who would make up the administrative interviews and the specialized interviews. The Agency Head, HR Director and the Agency PREA Coordinator's interviews were completed through video conferencing to reduce the number of individuals entering the facility.

Administrative Interviews	
Agency Head	Colleen Dobo Senior Vice President of Adult Services
PREA Coordinator	Reneta Chase Compliance Manager/Privacy Officer
Program Director/ Investigator	Jennifer Doutre Service Director- Adult
Human Resources	Turkessa Antrum Senior Vice President of Human Resources

The Auditor utilized regional resources identified by the facility to address specialized interview topics that the agency does not employ. These resources available in the community included a local rape crisis agency, a local hospital with SAFE/SANE trained staff, local police, and state agency representative who represent funding and an outside reporting entity. This process aimed to ensure enough resources were available to the clients in a sexual assault. The Auditor received information by email or through direct communication with individuals outside Milestone to determine standard compliance. The Auditor also did web-based searches for news stories, state laws related to mandated reporting, and state-required protocols for sexual assault case handling and SAFE/SANE Certification process requirements.
The Milestone program does not employ individuals who provide SAFE or SANE services. The facility is a treatment program with licensed clinical staff and a medical clinic that includes a doctor and a registered nurse.
Milestone has not had a staff who has acted in the role of First Responder since opening. The facility does not subcontract for the housing of residents and prohibits all cross-gender searches of residents. Where appropriate, the Auditor utilized information from random staff interviews to determine compliance in his review of standards. Community Health Resources employs 2 individuals who have completed the Administrative Investigating of Sexual Abuse training in a Correctional Setting, including the Service Director who oversees Milestone. The agency has provided this training after the onsite audit visit. Criminal Investigations of a sexual assault at Milestone would involve either the Putnam Police or the State Police. There is an Intake Clinician who completes all admissions at Milestone, including the PREA Screenings.

Specialized Staff Interviews

Positions described in standards	Title or agency that provided information to answer required questions.
Agency Contract Administrator	N/A – no subcontracted beds
Medical Staff	Day Kimball Hospital Windham Hospital Milestone Program Nurse
Mental Health Staff	Milestone Clinical staff Milestone Clinical Director
Individuals who have done cross gender searches	N/A Agency Policy prohibit all cross-gender searches.
Administrative Staff	CHR Vice President/ Director of Human Resources
SAFE/SANE	Windham Hospital
Volunteers or Contractors who have contact with residents	N/A
Screening / Intake Staff	Intake Clinician
Criminal Investigator	Putnam Police Department
Local Rape Crisis Agency	Sexual Assault Crisis Centers of Eastern CT
Individuals responsible for retaliation monitoring	Service Director
First Responder	Random staff answers were used since no individual has had to act as a first responder.
Funding/ Referral Source	Representatives of CT Judicial Branch
Outside reporting service	A representative of the CT Department of Mental Health and Addiction Service. (DHMAS)

The Auditor worked with the facility Administration to identify *Targeted Residents* for interviews to be completed. The current population makeup did not allow for identifying residents in each of the targeted categories for Community Confinement facilities as promulgated by Auditor Handbook. Milestone did not have any current resident who identified as transgender or intersex, nor did they have any individual who had claimed sexual abuse. Due to the program's small population, all residents were asked random resident questions, and where appropriate the Auditor asked the targeted questions for those identified in the population. There were four clients on day one, and two admitted on day 2. One client refused to be interviewed, and one of the new client's admitted on the second day was too emotional to complete an interview.

Resident Interviews for facilities with 0-50 population		
		Population Day 1 = 4 Admission day 2 =2
	# Interviews Required	# of Interviews Completed
Random Residents	5	2
Target resident Interviews	5	
Resident with Physical Disability	1	1

Resident who are blind, Deaf, or hard of hearing		
Residents who are LEP		
Residents with a Cognitive Disability		
Resident who Identify as Lesbian, gay, or Bisexual	1	1
Residents who Identify as Transgender or Intersex	1	0
Resident who reported Sexual Abuse	1	0
Resident who reported victimization during screening	1	1
Total	10	4

The Milestone program did not have any allegations of Sexual Assault in the 36 months before the PREA audit. The Auditor reviewed the agency's third-party reporting system and made outreach calls to the posted numbers observed on the tour and the agency's website. The Auditor confirmed this information provided in the Pre-audit tool with agency and facility staff and residents while on site. The Auditor also confirmed with community agencies and referral sources that they were not aware of any such complaints. As a result, there were no criminal or administrative investigative files to review. Similarly, there were no PREA related Grievances. This was confirmed through discussions with the Service Director, the PREA Coordinator, the residents, and the referring agencies.
The Auditor was provided hard copy documentation and shown documents from the electronic case management system while on site. A total of 23 current and former client files were reviewed in the pre-audit and on-site phases. The Auditor requested dates for various staff records elements that support compliance on 6 of 13 employees at Milestone. The Auditor was provided the requested Human Resource records for inspection. The Auditor completed a video interview with the Human Resource Director confirming the information in the employee files and the agency's process around hiring and discipline of staff.

Onsite Documentation Reviews			
Client Files	Total population	4	4 current 18 reviewed 22 total files reviewed
Human resource files	Total Staff	13	6 reviewed
Medical record	No clients required medical services related to PREA allegations		
Mental health records	Intake, screening and documentation provided		
PREA Grievances	No Grievances filed		
Written request or third-Party Complaints	No filings related to PREA		
Number of PREA Sexual Abuse Investigations	There were no claims of Sexual Assault requiring investigation		

Number of Notifications from outside reporting source	There were no notification of sexual abuse allegations from DMHAS or other sources

At the closure of the second day, the Auditor held an exit meeting. In attendance was the Service Director, Residential Supervisor, Clinical Director, and the Vice President of Adult Services. The Auditor thanked the team members for a supportive audit process by which staff and residents were easily accessible. The Auditor reviewed some of the staff and resident comments during the audit process, which supported a positive environment. Residents reported the facility is safe especially related to PREA and could approach staff with a problem and felt it would be looked into. The Auditor discussed things that could aid in documenting files moving forward. The Auditor described the post-audit process, which will require the Auditor to review the sum of all information provided, including documents, interviews, and observations. The Auditor stated the process must include how all indicators of the PREA standards must be considered in determining compliance. The Auditor and the team discussed outstanding items that would require resolution before compliance determination.

During the post-audit phase, the Auditor worked with the Service Director to address deficiencies. The agency needed to have specialized training for medical, mental health, and administrative investigations. The Agency and Auditor worked on an outside reporting option, secondary language materials, the improvement of its coordinated response plan, and PREA information posting to the agency website. The Service Director worked to ensure the solutions were consistent with the agency's overall practices and become an institutionalized process of the Milestone program. The Auditor provided guidance on standard expectations and best practices. An example of the agency's commitment to providing best practices is in the utilization of a professional translation service instead of relying on a computer program or employee to translate the material.

The agency had a few trainings to complete and some modifications to the agency website to publish PREA information which went beyond the initial 45 days after the site visit. As a result, the Auditor had to issue an interim report. During the corrective action period the Auditor worked with the agency's Service Director and others to obtain required documentation to meet the standard requirements. In the end the Community Health Resource's Milestone program came into compliance.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics, and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Milestone treatment program consists of two buildings, one three-story structure that houses sleeping quarters, treatment spaces, and living spaces. The second building houses the facility's dining hall, which doubles as a group and visitation space. The Community Health Resources facility is in the rural northeast corridor of Connecticut in an older mill town. The property is wooded, and there were small seating areas outside for clients of the residential programs. The facility has three programs utilizing the site. The program houses a methadone maintenance clinic, a small residential drug treatment program for women and children, and the Milestone population. The day treatment methadone program has a separate entrance from the residential programs. The two residential programs have their own defined spaces. The Milestone program has two floors of housing, though all residents were on one level because of the current population size. The first-floor housing unit has six (6) bedrooms with two singles and four doubles. The lower level has ten beds with four doubles and two singles. Each floor has two private bathrooms, a common area with televisions, and staff office space. There is a separate second floor with clinical offices, facility management offices, and a small group space used by the Auditor.

The line staff supervising clients are called residential aids. The program requires two staff in the Milestone program during the waking hours, of which one must be a female staff. The overnight minimum is three staff between the two residential programs. Staff, called Residential Advisors, are trained to not enter the client rooms except when completing room searches. Staff will open doors to clients' rooms after knocking to complete headcounts. Residents are required to be clothed at all times and can only change in the client bathrooms. The Residential Advisors office has a large window looking out over the common area. Residents are prohibited from the office, which has a Dutch door to allow for medication distribution. The program currently employs 13 full-time employees, including clinical and residential staff and supervisors. The facility's nurse works across all three programs on site and they have approved three per diem relief staff from one of their other residential programs to work at Milestone.

The staff secure facility serves female residents who must agree to attend the 28-day drug program voluntarily. The facility is not a correctional facility and does not house immigration (ICE) detainees or individuals for the US Marshals Service. The facility provided data supporting its population over the last 12 months; the average population was 13, with approximately 184 admissions. The facility does not currently have cameras in the Milestone portion of the complex though discussion with the agency administration confirmed they are considering their use in common areas. Residents are not strip searched, pat searched, or wand searched upon return from the community, and residents are subjected to urine screens monitored by the same gender staff as the resident. When first admitted, clients are asked to change privately into scrubs while staff search their belongings.

PREA related materials were visible upon arrival at the facility, as was the notice of the audit. Staff performs random tours of the facility, including bedrooms and bathrooms, hourly. Residents confirm opposite gender staff do not enter any bedroom or bathroom. The agency has a dress code for residents when in common areas. In bedrooms, all residents must be fully clothed while sleeping to eliminate incidental viewing incidents. The facility has handicapped-accessible rooms for those with

disabilities. The facility does have single occupancy rooms, which could be used to house Transgender residents if needed.
Throughout the tour, the Residential Supervisor showed her knowledge of the potential blind spot hazards and discussed practices employed to address clients' safety. Staff on duty make random tours of the facility all day to ensure client safety and facility security. The facility does not currently have any cameras or electronic surveillance equipment. When escorting clients into the community, the staff report they call the facility when they arrive and leave locations by practice.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: *No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Standards Exceeded

Number of Standards Exceeded: 2
List of Standards Exceeded: 115.215, 115.217

Standards Met

Number of Standards Met: 40

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: Click or tap here to enter text.

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- 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 facilities? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.21 Prison Rape Elimination Act (PREA)
Policy MIL 1.05 PREA Community Confinement Standards
Policy GAP 1.06 Anti-Harassment including Sexual Harassment
Policy GCC 1.02 Adult Residential Services – Consumer Rights
Agency Leadership Chart
Divisional Leadership Chart

Individuals interviewed/ observations made.
Interview with PREA Coordinator (PC)
Interview with Senior Vice President confirming PC authority/duties.
Interview with Services Director confirming PC coordination.
Interview with Staff
Interview with Residents

Summary determination.

Indicator (a). Community Health Resources (CHR) has a policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policy, Mil 1.21 Prison Rape Elimination Act, states its expectation on page one with the statement, “CHR 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 clients, is prohibited and subject to administrative and disciplinary sanctions. CHR staff shall take prudent measures to ensure the safety of both client and staff.” The Auditor has reviewed the policy that further outlines the agency’s efforts to build and support a zero-tolerance culture toward sexual abuse and sexual harassment of Milestone's clients. The policy describes different steps the agency will take to prevent, detect, and respond to sexual abuse or sexual harassment claims. The policy uses language from the federal standard to define sexual abuse and sexual harassment. The reader is informed on topics including the screening and monitoring of clients, treatment for victims, and the investigative processes in place if an allegation was to occur. Interviews with residents and staff also support an understanding of zero tolerance.

Indicator (b), CHR does employ a senior staff member to act as the agency’s PREA Coordinator. At CHR, the title ‘PREA Compliance Manager’ is used to describe Reneta Chase's role, who is the individual in charge of PREA compliance across the agecy. The agency chart and the PREA Policy show the relationship between the Milestone program and the overall agency. The PREA Compliance Manager works under the Senior Vice President of Quality, Operations, and Compliance. As a licensed mental health provider and an accredited agency by the Joint Commission, there is already a relationship between the Milestone program and CHR administration. Interviews with the Senior Vice President support the PREA Compliance Manager had sufficient access and authority to influence policy and ensure the agency’s continuing efforts to remain PREA compliant. Interview with the Senior Director of Milestone Jennifer Doltre supports the ongoing communication and support from the PREA Compliance Manager. Director Doltre oversees the Program Director and also ensures the facility's continued efforts toward PREA Compliance. Staff interviews support they understand the zero-tolerance culture and the role of the PREA Compliance Manager.

Compliance Determination
The Auditor finds that the agency promotes a zero-tolerance culture toward sexual misconduct. The interviews supported policy statements about protecting, detecting, and responding to sexual assaults or sexual harassment. Interviews with staff and residents further supported an understanding of zero tolerance. Documents confirmed the stated relations between the agency administration. The Agency reports being trauma-informed, and the residents, some of whom have been in institutions previously, said the environment was safe from sexual misconduct. The Milestone residents' voiced confidence if they had a concern, the staff would address it immediately. The compliance determination is based on policy, documents provided, and the various interviews completed.

Standard 115.212: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.212 (a)

- 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 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.) ☐ Yes ☐ No ☒ NA

115.212 (b)

- 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.) ☐ Yes ☐ No ☒ NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
CHR Website

Individuals interviewed/ observations made.
PREA Coordinator
Service Director

Indicator Summary determination.

Indicator (a). Milestone is not a public agency; it is a private non-profit drug treatment program. Two of the sixteen beds are funded through a contract with the Court Support Services Division of the Connecticut Judicial Branch. It does not subcontract beds to any other vendor.

Indicator (b). Milestone is not a public agency; it is a private non-profit drug treatment program. Two of the sixteen beds are funded through a contract with the Court Support Services Division of the Connecticut Judicial Branch. It does not subcontract beds to any other vendor.

Indicator (c). Milestone is not a public agency; it is a private non-profit drug treatment program. Two of the sixteen beds are funded through a contract with the Court Support Services Division of the Connecticut Judicial Branch. It does not subcontract beds to any other vendor.

Compliance Determination

The standard is compliant. Currently, there is no subcontract of beds with any other agency. Milestone is part of Community Health Resources, a private non-profit organization. Information was confirmed through discussions with the Agency PREA Coordinator, Service Director, and agency website review.

Standard 115.213: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- 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 ☐ No 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document, and justify all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.213 (c)

- 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 ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21 Prison Rape Elimination Act (PREA)
Milestone Staffing Plan
Milestone floorplans
Milestone patient demographic information
Milestone staffing matrix

Individuals interviewed/ observations made.
PREA Coordinator
Service Director
Random Residents
Random Staff

Indicator Summary determination.

Indicator (a). Milestone has a narrative staffing plan that describes the efforts to provide adequate supervision of the residents in promoting a safe environment. The document addresses the physical layout of the facility and the location staff. In speaking with the agency leadership, it is clear they take

into consideration all incidents, not just PREA events, in deciding staffing and video surveillance needs. During the onsite portion of the audit, the Auditor was able to see the positioning of offices that support residents' supervision. The facility has had no cases of sexual assault in the past three years, and when redesigning the facility, they added cameras to improve supervision. Policy MIL 1.21 (page 3) addresses this indicator's elements by defining the staffing plan's content expectations. It states, “Once per year, the PREA Facility Compliance Manager shall review the staffing plan in order to assess, determine and document whether adjustments are needed to amend the staffing plan, prevailing staffing patterns, the deployment of a video monitoring system and other monitoring technologies and the resources the facility has available to commit to ensuring adherence to the staffing plan.” Interviews with the Service Director further support knowledge of the aspects to be considered initially and in an annual review. The Auditor made some suggestions on improving the plan's presentation to include more information on support and management staff work hours.

Indicator (b). Milestone has not had a situation where they have not met the facility's minimum staffing in the past 12 months. The Service Director reports they can mandate coverage or call staff into work in an emergency to provide support. Interview with the Residential Supervisor also confirmed that she fills shift vacancies if there are no other staff available. The agency cross-trains staff from its adjacent women and children’s program to be able to cover shifts. The program has a minimum complement of 2 staff, of which one must always be a female during the day hours and one staff on the overnight.

Indicator (c). Milestone has a process in place by which the Program Director reviews the existing plan for adequacy in providing a safe environment for residents. The Service Director, who oversees the Program Director states there is a review process for the staffing plan including the elements described in this indicator. They would consider any PREA event findings or any other situation where the building's safety or security was compromised. The Senior Vice President and the PREA Coordinator confirmed that they would be consulted on any long-term changes and additions of resources such as video surveillance equipment. Senior Vice President and Service Director assure that immediate solutions would be put in place to resolve identified risks from incident reviews or investigations. Senior Vice President supports Community Health Resources' commitment to providing a safe environment at all times for the women of Milestone.

Compliance Determination
Milestone is compliant with the expectations of standards 115.213. The facility had a written plan that discusses the elements described in indicator (a) and a process for the annual review of staffing and technological needs to support residents' safety management. Community Health Resources supports the facility by providing additional resources when necessary. Interviews support regular discussion between facility and agency management and an expectation to resolve identified concerns immediately. Further confirming the agency's expectation is policy MIL 1.21 Prison Rape Elimination Act that put forth requirements consistent with the standard’s language.

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.215 (b)

- 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 residents.)
  ☒ Yes ☐ No ☐ 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 residents.) ☒ Yes ☐ No ☐ NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). ☒ Yes ☐ No ☐ NA

115.215 (d)

- Does the facility have policies 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? ☒ Yes ☐ No

- Does the facility have procedures that enables 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? ☒ Yes ☐ No

- 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 ☐ No

115.215 (e)

- 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 ☐ No

- If a 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 ☐ No

115.215 (f)

- 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 ☐ No

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
MIL 1.21 Prison Rape Elimination Act (PREA)
AR-SA 2.03 Searches in a Adult SA Residential Program
AR-SA 2.06 Drug Screening Urinalysis
GAP 101 Trauma-Informed and Gender Responsive Care.

Individuals interviewed/ observations made.
Service Director
Random Staff
Random Residents

Indicator Summary determination.

Indicator (a). Milestone has a policy prohibiting cross-gender strip or body cavity searches of a resident. Policy MIL 1.21 Prison Rape Elimination Act (PREA) states, “The program does not conduct cross-gender strip searches nor cross-gender visual body cavity searches under any circumstances.” The Auditor was also provided with a copy of the facility search policy (AR-SA 2.03 Searches in an Adult SA Residential Program- page 4), which had consistent language prohibiting staff supervised strip searches. Residents may be given scrubs to change in to, unobserved, to allow further inspection of their clothes. Interviews with administration, random staff and residents confirm no instances in which a strip or body cavity search occurs. Because the facility requires urine samples to be observed, the Auditor checked the policy and practice to determine compliance. The facility requires the same gender staff to observe the collections of urine samples for drug testing. Policy AR-SA 2.06 Drug Screening Urinalysis (page 1) requires “Drug screening urinalysis is performed by obtaining a urine sample from a client. In the event that a supervised drug screening is indicated, a urine sample will be obtained from a client by a staff member of the same sex.” The Auditor asked random staff related questions about how this process occurs, including if cross-gender observations would ever occur. Residents interviewed confirmed that the same gender staff always collects urine samples. The Auditor was told that when the facility housed a transgender resident, consistent with the stated policy in AR-SA 2.06, their preference would be considered.

Indicator (b). Milestone is an all-female resident facility. The Agency policy AR-SA 2.03 Searches in an Adult SA Residential Program clearly states the “pat-down searches are never to be conducted”. They have a process to control contraband by allowing a resident to change into hospital scrubs to allow the staff to go through the resident's clothes. Residents and staff interviewed all supported there are no pat searches of residents at Milestone.

Indicator (c). As noted in indicator (a), there are no strip or body cavity searches at Milestone. The Auditor also confirmed that urinalysis testing samples are observed only by same-gender staff. The Auditor’s interview with random residents confirmed the Milestone's same-gender practices, including if an observed urinalysis test was required. The Drug Screening and Urinalysis policy also supports the use of the gender staff with whom a transgender individual feels more comfortable.

Indicator (d). Community Health Resources policy MIL 1.21 Prison Rape Elimination Act (PREA) has language that addresses the requirements of this indicator. The policy protects residents from being viewed in any state of undress except in incidental view on security rounds. The Policy states, “The program enables residents to shower, perform bodily functions, and change clothing, without any staff observing them. The 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.” In interviews with random staff, they confirmed that opposite gender staff announces their presence when entering a resident room or bathroom where residents are likely to be showering, performing bodily functions, or changing clothes. The Auditor also confirmed with residents that they could shower, use the bathroom facilities, and get changed without the opposite gender staff seeing them. The Auditor also observed practices on tour and while moving about the program during the audit's onsite portion. All the bathrooms in the facility are designed for single person use, they

include showers, and the resident is expected only to change clothes in this space. Residents support all staff knock before opening their bedroom doors. Male staff will not do room checks out of an abundance of caution to those who might have trauma issues.

Indicator (e). The Service Director and Clinician who completes intakes confirm they would not strip search an individual to determine genital status. Policy MIL 1.21 Prison Rape Elimination Act (PREA) (page 3) states, “Under no circumstances will a staff search or physically examine a person who identifies as transgender or intersex for the sole purpose of determining the resident’s genital status.” As noted in indicator (a), the facility does not perform any strip searches or body cavity searches of clients. The Clinician reports that if a person’s genital status were unknown, they would ask them. Interviews with the clinical team confirmed that they try to give information to transgender individuals about the program in advance of the admission so they can understand expectations and can discuss how they can mitigate any of the client’s concerns. In addition to the pre-admission meeting, the clinical team reports they will meet with the client when they arrive to further support their transition into the environment. Milestone is a staff secure treatment facility; all admissions are scheduled, and information about the resident, including one's sexual identity, would likely be obtained in advance. There were no current Transgender individuals in the population for the Auditor to confirm practices.

Indicator (f). The Community Health Resources prohibits cross-gender pat searches or searches of transgender individuals. The facility has a policy to address urines' supervision if required, including how a transgender resident would be asked with whom they feel more comfortable. Policy AR-SA 2.06 Drug Screening Urinalysis (page 1) also allows unobserved urine to be consistent with gender-informed practices if the staff person is not available.

Compliance Determination

The Auditor finds Milestone compliant with the standard expectations on cross-gender searches or viewing. Community Health Resources has implemented a policy of no strip searches or body cavity searches and no pat searches. The agency and facility management confirm they have managed security issues in a staff secure setting while avoiding more intrusive and potentially traumatic practices of searches of any type. Clients can be asked to turn out pockets, shake out clothes, or be asked to change into scrubs unobserved so staff can go through their clothes more thoroughly. The agency has a policy, GAP 101 Trauma-Informed and Gender Responsive Care that defines the agency’s commitment to limit traumatic situations. The Service Director confirms that as a trauma-informed agency with clientele who often have abuse histories, they have determined the emotional risk of pat or strip searches is not needed in a population that is there voluntarily. The intake Clinician and line staff confirmed no searches are performed to determine genital status and that strip searches do not occur at Milestone. Transgender or Intersex residents who disclose at intake would be asked questions at intake about genital status. In the case of transgender residents coming from correctional centers, the facility would receive information in advance.

Staff and residents both confirmed there are no strip searches as a practice and no cross-gender pat searches. The Auditor also confirmed with the residents the agency practice of same-gender staff observing urine samples being secured for drug testing. The facility policy, observations of the physical plant, and observations made of staff practice support residents are able to shower, perform bodily functions, and get changed without opposite gender staff seeing them. Residents support staff provide

appropriate notice before entering the bedroom or bathroom areas. The Auditor finds that the standard has been exceeded. All elements required have been met as discussed above; the Auditor believes Milestone exceeds the standard by creating an environment in which residents feel safe while removing all strip searches and pat searches.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.216 (a)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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: Are blind or have low vision? ☒ Yes ☐ No

115.216 (b)

- 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 ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.216 (c)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
MIL 1.21 Prison Rape Elimination Act (PREA)
MIL 1.05 PREA Community Confinement Standards
Policy GCC 4.04 Interpretive Services for Individuals with Limited English Proficiency or who are Deaf/Hearing Impaired
Language Link Contract
I Speak Cards
Referral Paperwork/ Intake Paperwork
Resident Handbook

Individuals interviewed/ observations made.
Senior Vice President
Random Staff
Random Residents

Indicator Summary determination.
Indicator (a). PREA policies 1.21 and 1.05 require the identification of populations who may have difficulty in understanding information. Policy 1.21 states, "The facility will also ensure meaningful access to its efforts to prevent, detect, and respond to sexual misconduct to clients 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." As a drug treatment facility, admissions are coming from state prison, probation, and the community. Prescreened admissions allow for the identification of individuals with disabilities or language barriers. Milestone receives information in advance about residents with significant medical issues/disabilities or other mental health disorders that may make understanding PREA information difficult. The Intake Clinician sits with each new resident and screens for any missed medical information or other factors that may impair their understanding of the facility rules, including the zero-tolerance policy toward Sexual Abuse and Sexual Harassment. This screening would help identify those who have comprehension or limited reading ability. The PREA Coordinator confirms the agency can provide written materials to clients in various formats and languages as needed. The Auditor was provided copies of the Resident Handbook in English and viewed posting of PREA information in multiple languages during the tour. The Auditor asked for a copy of the handbook and the Intake acknowledgment form to be produced in the most common second language spoken. Residents interviewed with disabilities confirmed there was staff

available with whom they could ask and receive assistance in comprehension or accessing any part of Milestone's efforts to keep them safe from sexual abuse or sexual harassment.

Indicator (b). Milestone has signage up related to PREA and other important information in both English and Spanish, the most common languages spoken by their population historically. Intake paperwork and handbooks can be translated into multiple languages as needed. The agency has provided access to interpretive services consistent with its commitment described in policy GCC 4.04 Interpretive Services. “CHR will take reasonable steps to ensure that individuals with LEP or who are deaf and/or hearing impaired have equal access and equal opportunity to participate in CHR’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, etc.” The Auditor was able to learn how staff would access the system if needed. There were no residents who were limited English proficient for the Auditor to interview. Residents acknowledged there was some staff whom they could approach who could aid in their understanding of information. The Auditor confirmed this with random residents and a resident with developmental disabilities. Random staff interviewed knew about their responsibility to help clients understand how to report a concern.

Indicator (c).
Random staff interviewed confirmed that resident interpreters are not appropriate in any communication about concerns of sexual misconduct. Staff are aware that it is only right to do so on an emergency basis to find out information sufficient to obtain appropriate medical care. The staff was aware of the existence of interpretive services. Training records and materials support the expectation that has been made apparent to staff. All staff reports awareness of how to use the “I Speak” card to identify the language the client speaks as the first step and then calling the agency’s interpretive contractor.

Compliance Determination
Milestone is compliant with the expectations of providing full access to Limited English Proficient (LEP) and disabled residents' ability to benefit from its efforts to prevent, detect, and respond to sexual misconduct. The facility can aid disabled or LEP residents in understanding PREA, how to report a concern, and how to access assistance if one has been a victim. The agency had provided documentation, and the Auditor could see on tour how LEP or disabled individuals could access information. The agency’s website has client rights, grievance policy, and privacy policy in English and Spanish. Residents' interviews supported staff are available if they are having difficulty with comprehension. During the post-audit period, the facility provided examples of the handbook and acknowledgment form in Spanish. Staff interviews confirm the ability to aid the residents in all aspects of the facility's effort to have a zero-tolerance, PREA safe environment. The Auditor considered policies, interviews, and the posted documentation on how to report a concern or access outside support in determining compliance.

Standard 115.217: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.217 (a)

- 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 ☐ No

- 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 ☐ No

- 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 question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of 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 ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of 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 question immediately above? ☒ Yes ☐ No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.217 (c)

- Before hiring new employees who, may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- 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 ☐ No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.217 (e)

- 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 ☐ No

115.217 (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 ☐ No

- 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 ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.217 (h)

- 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 ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy GAP 2.05 Background
Policy MIL 1.05 Community Confinement PREA Standards
Policy MIL 1.21 Safety and Security PREA
Criminal Background Checks
Employment applications
Prior Employer Inquiry forms
Random Staff Files.

Indicator Summary determination.

Indicator (a). The Community Health Resources policy Gap 1.05 covers much of the language of this standard Indicator. The Auditor's review of forms and hiring documents found additional language consistent with the standards expectations. The policy strictly prohibits the employment or contracting the services of individuals who "is prohibited by law or contract from providing services for the organization's clients." has a human services agency the staff and administration consistently voiced concern on protecting resident's safety. All individuals with whom the agency completes a criminal background check must sign a release form during which they are asked to certify the following, "I understand that I may have contact with individuals who are under the supervision of the Judicial Branch and certify that the following statements are true (check all true statements):
0 I have never engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution.
0 I have never been convicted of engaging or attempting to engage in sexual abuse.
0 I have never been civilly or administratively adjudicated to have engaged in sexual abuse or sexual assault."
Milestone does not currently hire contractors who have regular contact with residents. The Auditor confirmed that Interns at Milestone are required to complete the same background check process as full or part-time staff. Human Resources Director confirmed that individuals with past histories described in indicator a) would not be eligible for employment. Any one-time contractor, such as persons completing service repairs, would be supervised by staff while on-site reportedly. These individuals would also be informed about PREA and the residents' right to be free from sexual abuse or sexual harassment.

Indicator (b). As noted in indicator (a), Milestone does not contract with individuals who provide direct services to residents. The Human Resources Department for CHR will review all employees recommended for promotion. It will require the PREA Employee Questionnaire to be completed, followed by a complete Human Resources file review. The Human Resources Director confirmed if they identified past sexual harassment concerns in the staff file in this review. The information would be referred to the executive team before a promotional offer would be extended.

Indicator c). Community Health Resources policy GAP 2.05 Background checks states "All employees, contractors, temporary (TEMP) services, and student intern candidates, as well as volunteers, are subject to the following background checks, which will be filed in a separate file outside of the individuals personnel file:

- Verification of prior employment, academic degrees, and required professional licenses or certifications (as indicated for student interns, TEMP workers, and volunteers).
- State Police criminal history check (includes pending arrest information)

i. For employees, student interns, or volunteers from Connecticut- Connecticut State Police Criminal History Check.

ii. For employees, student interns, or volunteers from other states- The relevant state's State Police Criminal History Check.

- DCF protective services screening (the State of CT and if applicable the state in which the employee, student intern or volunteer resides).
- Criminal county history check – verification of every county the employee, student intern or volunteer has resided.
- Motor vehicle check.
- Automobile insurance check."

The Auditor was provided information supporting all current employees have had an initial criminal background check. The Auditor reviewed the files of 6 of the programs 13 employees. In addition to the policy, background checks are a requirement of the funding source. The agency also has in place a system to make inquiries of prior institutional employees. The Human Resources Director and the Service Director both committed to the agency's efforts to protect clients through seeking information about previous misconduct.

Indicator (d). As noted in indicator (c), Milestone and CHR policy requires all contractors who have contact with clients to undergo criminal background checks. All visitors to the facility are monitored by staff when on-site and are registered. The facility has no contracted personnel working with Milestone's clients. Given COVID-19, outside individuals coming to the facility have been limited to services needed to keep the program going (i.e. emergency repairs or required licensing visits or heath or fire inspections.)

Indicator (e). Community Health Resources requires all employees and contractors to undergo a criminal background check every two years. Policy GAP 1.05 states, "CHR will routinely obtain the following checks every (2) two years for all employees, student interns, temporary services workers, and volunteers:

- State Police criminal history check
- DCF protective service screening

- Criminal county history check
- credit check."

The Auditor asked and was provided documentation of employees who had multiple checks in their personnel files. The Agency's practice exceeds the standard expectation.

Indicator (f). All new employees are asked about prior sexual misconduct as described in indicator (a) The Auditor reviewed the record and found the questions are part of the Milestone's applicant's reference release form they sign. These documents are reportedly completed upon hire and upon promotion. This document asks all prospective employees about the required element in the indicator mentioned above. The employee signs the form after they read the information. The Agency also set forth a continuing affirmative duty to disclose any criminal behavior. The agency policy Gap 2.05 Background checks states, "Employees are required to notify the Vice President, Human Resources if they are arrested or convicted of any felony or misdemeanor within one day of the action. CHR will take into consideration all facts and circumstances related to the arrest in making any decisions based on the employee's employment status, and will not make decisions based solely on the fact that the employee was arrested."

Indicator (g). The Community Health Resources employee application contains the following passage: "If you fail to complete information on this application form, or if you provide any false or misleading information here or in any part of the application process, your application will not be further considered. The employee signs a second page with similar affirmative statements. "If you are employed by Community Health Resources, the discovery of omissions, misrepresentations or misleading information in the application process will be cause for termination of employment." Human Resources Director and the Service Director confirmed they have not had to fire any individual at Milestone for any such inaccuracies related to any sexual misconduct.

Indicator (h). CHR does complete background checks of all applicant's prior work history. The Auditor was provided examples of the forms completed by the prior employer and reviewed the random staff files selected to ensure consistent practice. The Auditor found the agency has a good record of getting responses back. The prior employer is prompted to answer the following question, "Are you aware of any substantiated allegations of sexual abuse or any resignations of this candidate during a pending investigation of sexual abuse?" Interviews with Human Resources Director confirm they make requests of outside employers when hiring; she also confirmed they would provide similar information with appropriate releases to other agencies.

Compliance Determination

The Community Health Resources is compliant with the hiring and promotion decisions required by PREA. The agency has policies (in place to address the requirements of the standard, including the screening of individuals for sexual abuse or harassment histories. The agency has all staff working in their agency regularly undergo criminal background checks. Interview with the Human Resources Director was completed over the video call to limit any chance of cross exposure between facilities of CHR. The Auditor received electronic copies of random staff files after completing an initial review with the HR Director. The Auditor reviewed a sample of six of the 13 current staff. The process allows the

Auditor to confirm the hard documentation of selected files against the previously stated practice. Documentation from the personnel files supported the requirements of this standard, including asking employees about past sexual misconduct, responsibilities of continuous disclosure, and consequence for omission or falsification of information. In determining Milestone's compliance, the Auditor reviewed staff files, policy and forms scanned for required elements of the standard, and interviews with CHR Human Resource Director and the agency's PREA Coordinator. The Agency has policies, procedures, and practices in place to support ongoing compliance. Interviews with human resources, agency, and facility administration further support the needed communication and practices are maintained. The Auditor has determined the standard has been exceeded. Though Milestone is a very small portion of the Community Health Resources agency, the agency has in place mechanisms to ensure individuals with past abuse histories are identified. CHR makes clear in its hiring practice there is zero-tolerance toward any form of misconduct or mistreatment of residents in all of its programs. The agency goes beyond the standard by requiring criminal background checks every two years. CHR also requires all individuals working in their programs to undergo child abuse/neglect background checks. This is normally reserved for juvenile facilities in the PREA standards but is a potential source of identifying individuals with abusive histories.

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.218 (a)

- 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.)
  ☐ Yes ☐ No ☒ NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.

Individuals interviewed/ observations made.
Service Director.

Indicator Summary determination.

Indicator (a).
The program has not undertaken any significant modifications in the past three years

Indicator (b
The program has not modified any monitoring technology or video systems in the past three years.

Compliance Determination
The Community Health Resources Service Director reports no significant changes to the program's physical plant or the programs monitoring technologies. There is a planned renovation to the dining area, but the plans will not impact sightlines. The Service's Director reports that the agency is considering acquiring video surveillance equipment for common areas to aid in client movements' supervision.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.221 (a)

- 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 ☐ No ☐ NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- 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 ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.221 (e)

- 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 ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.221 (f)

- 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 ☐ No ☐ NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- 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 *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
MIL 1.21 Prison Rape Elimination Act (PREA)
MIL 1.22 PREA Coordinated Response Plan
MIL 1.05 PREA Community Confinement Standards
MOU with Sexual Assault Crisis Center of Eastern CT

Website of CT Judicial Branch. (SANE Training Program)
Websites of Connecticut Alliance to End Sexual Violence.
CT.GOV- CT Guideline for Sexual Assault Exams
Website of Sexual Assault Crisis Center of Eastern CT

Individuals interviewed/ observations made.
Day Kimball and Windham Hospital representatives
Discussion with SACCEC staff
PREA Signage (English/Spanish)
Putnam Police Representative

Summary determination.
Indicator (a). Criminal Investigations at Milestone would be the Putnam Police Department's responsibility or the Connecticut State Police's responsibility. The administrative investigation would fall under CHR's purview. Milestone staff would not be involved in evidence collection but are trained as part of first responder duties to seal off potential crime scenes and instruct potential victims and perpetrators to preserve evidence. The State of Connecticut sets forth the state protocols for sexual assault cases. The 2017 state guidelines help investigators maximize the collection of evidence that can be used in the prosecution of perpetrators. The Auditor reviewed the 122-page document, which included guidance for criminal investigators, sensitivity and cultural concerns when working with victims, and evidence collection. The protocol, developed under the guidance of a committee of the state medical, legal, scientific and advocacy experts, also addresses topics including the rape crisis advocate's role, the offering of prophylactic medications, STD testing, and emergency contraception, and the payment of services by the state. The Connecticut Judicial Branch also provides the training of all SANE nurses in the state.

Indicator (b). Milestone would not house any youthful individuals for treatment as its bottom age is 18. As noted in Indicator (a), the Milestone treatment staff would not be involved in any evidence collection or part of performing a criminal investigation. The random staff have been informed on the steps to preserve evidence, including closing off the scene and educating the victim on steps to preserve evidence until they are transported to the hospital for a forensic exam. The State of Connecticut has guidelines for the sexual assaults of juveniles and adults. The 2017 guidelines were developed utilizing

the collective effort of some 13 individuals who are experts in legal, criminal, medical, and mental health services. The experts involved in the development of the document were a representative of the umbrella rape crisis agency (Connecticut Alliance to End Sexual Violence), the state police, and the Chief State's Attorney. Like the national protocol, the document includes both technical aspects of evidence collection with information about working with victims of sexual abuse.

Indicator (c). Milestone has provided documentation in its Coordinated Response Plan that resident victims are sent to the hospital. The local hospital nursing supervisor reported the Day Kimball Hospital does not currently have SANE certified nurses. The Auditor did outreach to Windham Hospital in Willimantic, which is about 25 miles from Milestone. The Hospital confirmed they have several staff nurses trained as SANEs. The Auditor spoke with hospital representatives as well as confirmed SANE availability at the hospital. If none are onsite, they can request a nurse from the state's on-call network of participating hospitals. Through interviews and what the website states, the Auditor confirmed that victims of sexual assault are provided service free of charge. The cost is covered by the state's Attorney General's Office through its Victims Compensation funds. If a SANE is not immediately on-site at Windham hospital, they can call one in. In discussions with the Service Director, they will ensure medically stable individuals would be requested to go to Windham Hospital instead of the local Hospital.

Indicator (d)) CHR has entered into a working relationship with the Sexual Assault Crisis Center of Eastern CT or SACCEC for short. SACCEC is a regional leader in providing rape crisis services to victims of sexual abuse. The Connecticut Alliance to End Sexual Violence provides a network of referral options for continued services after a client discharges. A Memorandum of Understanding outlines SACCEC's willingness to work with Milestone. Page 3 of Policy MIL 1.05 Community Confinement Standards (PREA) sets forth the agency's responsibility to provide residents with access to a rape crisis agency. The policy states, "CHR will attempt to make available to the victim a victim advocate from the local rape crisis center. CHR will document efforts to secure services from rape crisis centers. As requested by the victim, the victim advocate or qualified CHR staff member will accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals." There are no current residents accessing services at SACCEC. SACCEC can not only provide crisis services and supportive counseling; it also can provide clinical services to individuals struggling with their victimization history upon discharge from Milestone's 28-day program. Representatives of SACCEC confirmed they had provided supportive services to clients of Milestone who reported past abuse. She confirmed that they could provide support during hospital or during police interviews.

Indicator (e). A representative of SACCEC confirmed they provide support for victims of sexual abuse, including support during forensic exams, investigative interviews and on-going support services. The agency confirmed they would aid a resident at Milestone in finding a support network if they move to another area at the time of release. Hospital Staff confirmed its protocol to offer SACCEC services to victims of sexual assault. The Milestone Coordinated Response plan requires the Program Supervisor or Case Manager on Duty to notify SACCEC to request they come to meet with a victim or to meet the victim at the Hospital if the client agrees to go for an exam. COVID-19 has impacted some of the efforts to expand resources to the clients onsite at Milestone. SACCEC has been reportedly able to provide virtual support to victims during a forensic exam at local hospitals. As noted in indicator (d), CHR policy

supports access to rape crisis support during forensic exams or investigatory interviews. “As requested by the victim, the victim advocate or qualified CHR staff member will accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.”

Indicator (f). The Auditor was able to confirm with the Putnam Police that they would investigate criminal incidents at Milestone. The Police confirm there is state protocol to guide the investigative team in completing sexual assault investigations. The Officer confirmed that the victim could have the support of a victim's advocate during the exam and any police interview. The Service Director confirmed the Facility Director would be the point of contact if an investigation occurred. The Service Director was aware of the need to obtain sufficient information to aid any administrative investigation and to ensure proper notifications are made consistent with PREA standards (115.273

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

Indicator (h). The agency will make a victim advocate available through SACCEC, so the indicator is NA. As a substance abuse treatment agency, with the client’s permission, they are willing to work with the rape crisis agency in providing a coordinated treatment and discharge plan.

Compliance Determination: The Auditor finds Milestone is compliant with this standard’s expectations. Though the facility does not provide many of the services directly covered in the standard, the required elements are all found in the community, including SANE services at a local hospital, a police force with significant experience investigating sex crimes, and an active Rape Crisis Agency. In addition to the interviews, the Auditor found a great deal of information on the state website, which was consistent with the information I received verbally from Milestone leadership and the community contacts referenced above. The Auditor considered compliance, random staff’s knowledge of steps to be taken to help preserve evidence.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.222 (b)

- Does the agency have a policy and practice 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 ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

- 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 ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy GAP 1.61 Incident Reporting
Policy MIL 1.05 PREA Community Confinement Standards

Policy MIL 1.21 Prison Rape Elimination Act (PREA)

Individuals interviewed/ observations made.
Senior Vice President
Service Director
Agency PREA Coordinator.
Putnam Police Representative

Indicator Summary determination.

Indicator (a). Milestone has policies to ensure that all reported incidents of sexual abuse or sexual harassment are investigated. Policy MIL 1.05 states, “CHR Milestone shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.” (page 3). Interview with staff confirmed they must report all allegations of sexual assault or sexual harassment no matter the source or if they think the allegation is true or not to the Program Director. The staff also were able to describe the process of protecting evidence and documenting the incident. Agency response plans also ensure all allegations are investigated. Interview with the Senior Vice President confirms the expectation. She reports the agency will involve the PREA Coordinator and other agency resources to make sure a thorough review occurs in a timely fashion.

Indicator (b). As noted in indicator (a), the Milestone and Community Health Resources policy requires all criminal investigations be referred to the local police or the state police. CHR would ensure that non-criminal acts would be investigated internally. Publicly available agency policy defines the process. “CHR Milestone shall ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agent with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. CHR shall document all such referrals.” “CHR Milestone, for administrative investigations, shall: Determine whether staff actions or failures to act contributed to the abuse; and Document a description of the administrative investigative facts and findings. Substantiated allegations of conduct that appears to be criminal shall be referred to appropriate authorities for criminal investigation. CHR Milestone shall cooperate with external agencies conducting such investigations.” The agency PREA Coordinator receives information on all allegations and both she and the Service Director would document the referrals to any outside investigative body.

Indicator (c). As noted in indicator (a), the criminal investigation would be the local police or the state police's responsibility. The Service Director, who is one of the agency's trained investigators, confirmed she would ensure the police investigative officer is aware of the federal requirements on victim notification in PREA. She also reports she would set up regular calls to review the progress of the case. The Service Director also confirmed that if an administrative investigation found information that may support a criminal finding there would be immediate notification to the police. The Auditor confirmed the police role with a local police representative. The officer confirmed there are protocols in place that determine the steps taken during a criminal investigation. The department reportedly has experience working with the CHR facility site on issues outside of sexual assault cases. In the event of a crime, they will continue to work the investigation even after the clients leave the facility, which would be likely given the short term nature of Milestone.

Indicator (d). The Auditor is not required to audit this provision

Indicator (e). The Auditor is not required to audit this provision

Compliance Determination
The Auditor has determined the facility has met the requirements of the standard. The agency staff and administration know to referr all criminal acts to the police for investigation. The Auditor was able to confirm the relationship between the Milestone program and the local police in the event of a sexual assault. The Program Director was aware of the need to maintain communication with the police to be able to document the outcome in the agency records. Interviews with the agency PREA Coordinator, the Service Director, and random staff support all incidents of sexual abuse or sexual harassment will be referred for investigation.

TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- 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 ☐ No
- 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 ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☐ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No

- 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 ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- 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 ☐ No

115.231 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- 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 ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 PREA Community Confinement Standards
Training Records
Employee sign signature for trainings
CHR PREA training PowerPoint

Individuals interviewed/ observations made.
PREA Coordinator
Service Director
Random Staff

Indicator Summary determination.

Indicator (a). The CHR trains all Milestone staff, including part-time relief employees, on the agency's Zero Tolerance toward sexual misconduct, are trained all staff. The Auditor was able to read evaluations from the training stating it was informative and engaging. A review of the PowerPoint presentation and the accompanying exercises shows the ten topics required were addressed. The topics included 1) a zero-tolerance policy for sexual abuse and sexual harassment 2) the duty to protect, detect and respond to incidents of Sexual Assault or Sexual Harassment 3) the residents right to be free from abuse 4) both the staff and resident right to make a report without fear of reprisal 5) the dynamics of Sexual Abuse in institutions 6) signs and symptoms of a victim of sexual abuse 7) how to act in response to a disclosure of Sexual Assault 8) How to avoid inappropriate situations with residents 9) How to effectively communicate with LGBTI and gender non-conforming residents and 10) what mandated reporting requirements. Random staff Interviewed were able to give examples of the various elements of the training. In addition to being able to recount the content of the training, the staff confirmed the frequency of the PREA training.

Indicator (b). The PREA training for Milestone staff addresses how female victims may react to sexual misconduct. The Service Director confirms that if staff came from an all-male facility, the employee would be reoriented to working in all-female facility like Milestone. None of the current staff had transferred in from another CHR all-male facility. Milestone does train employees on PREA who may

work as relief staff. These individuals may work at their women's and children program or at a may facility about 20 miles away. The Service Director confirmed the relief employees are not eligible to work at Milestone until they complete the PREA training.

Indicator (c). Employees of Milestone are trained in the ten items required in indicator (a) upon hire and at a minimum of every other year. Milestone staff confirmed they participate in PREA related topics a minimum of once per year. Staff interviewed supported that information provided PREA training was retained. Policy MIL 1.21 requires, "Staff shall be trained on PREA twice a year and shall sign that they have attended the training. The signed attendance sheets shall be kept in the log." Staff were able to provide the Auditor with examples of what they have learned. The Auditor reviewed six staff training records to confirm, what staff had previously stated, Milestone staff receive PREA training at least annually.

Indicator (d). With COVID-19 the agency has moved to online education for the annual PREA training. The agency provides employees with a quiz on the content to confirm retention. The new employees to Milestone also have the information reviewed again with the facility leadership to ensure a complete understanding of the process. Interviews with staff confirm they understand the content of the training and have access to a supervisor who can clarify if they have any questions.

Compliance Determination
The Auditor finds Milestone is compliant with the requirements of this standard. Compliance is based on the materials presented relating to the training consistent with indicator (a). The agency provided documentation of employee's PREA training. (The training records for six individuals who were provided.) In addition to formal PREA training, the facility provides other related training the reinforce the information from PREA training. The final factor considered in determining compliance was the random staff interviews. Staff spoken with were able to relate the information they learned as part of the agency training, including examples of all ten elements covered in the indicator (a). The staff reported to the Auditor the training was effective; this was evident by the knowledge staff could relate back to the Auditor.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.232 (a)

- 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 ☐ No

115.232 (b)

- 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 ☐ No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 PREA Community Confinement Standards
PREA Training documentation intern/volunteers

Individuals interviewed/ observations made.
Service Director

Summary determination.
Indicator (a). Milestone does not contract for an individual to provide direct services to their residents, and due to COVID-19, there is only one intern, and no other volunteers allowed onsite. College interns are treated like the staff and receive full training in PREA. Historically other one-time contractors or volunteers such as Narcotics Anonymous Meeting Chairs are provided an orientation on PREA and the client's right to a sexually safe environment. The volunteers sign an acknowledgment form for their training. The Auditor was provided with several examples of this process from the pre-COVID-19 period. Policy MIL 1.05 sets forth that all individuals who have contact with residents have some level of education on the agency's Zero tolerance expectation and the efforts to prevent, detect and respond to sexual assault and sexual harassment claims. The Policy goes on to state, "CHR Milestone shall ensure that all volunteers and contractors who have contact with clients will be trained on their

responsibilities under the Milestone Program's zero-tolerance for sexual abuse and sexual harassment policies and procedures and are informed on how to report such incidents." The Service Director confirms that when the facility has volunteers with routine resident contact, they must meet with a facility administrator for PREA education.

Indicator (b). As noted in indicator (a), all volunteers and Contractors are required to be educated in the client's right to a sexually safe environment. COVID-19 protocols have canceled outside individuals from being able to come to the facility for the past nine months.

Indicator (c). Milestone keeps records of all individuals who are educated on PREA. The Auditor was provided documentation on the current college intern, and examples of other individuals from before COVID-19 canceled outside individual's ability to come to the facility.

Compliance Determination
In policy MIL 1.05, Community Health Resource addresses the standard language expectations. The Auditor was also able to view the training record and documents showing visitors are given information on residents' rights to sexual safety. Absent any contracted staff, the information provided and the interviews all support a determination of compliance.

Standard 115.233: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? ☒ Yes ☐ No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.233 (e)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy GAP 1.1 Trauma Informed Care
Policy GCC 1.02B Adult Consumer rights
Policy GCC 1.02D Consumer right grievance
Policy MIL 1.04 Admission Process
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21 Safety and Security PREA
Policy PHI 3.06 Retaliation
Milestone Handbook
Client records

Individuals interviewed/ observations made.
Random Resident
Intake Clinician
Service Director

Summary determination.
Indicator (a). Agency policy and Milestone practice support all residents are provided PREA Education upon admission. They are educated on the client handbook, including PREA information, the facility's Zero Tolerance for sexual misconduct, and how to report a concern. The Intake Clinician interviewed described the process by which she initially reviews materials with the clients. The forms can be provided in multiple languages. The Auditor was provided a Resident handbook, PREA postings, and the PREA education acknowledgment form in English and Spanish, the two most common languages spoken. Resident interviews support they know several ways they could report PREA concerns, that they would be protected from retaliation, and that being free from abuse is their right. Policies MIL 1.04, MIL 1.05, and MIL 1.21 speak to the content of resident education. Residents report they are provided information about PREA in the first hours in the facility and Clinical staff goes over their rights in their initial sessions.

Indicator (b). The Milestone does not receive or transfer residents to or from other CHR facilities. As a treatment facility, not all residents have prior criminal justice involvement, so PREA information is new to them. Some residents disclosed that they had prior correctional stays and that they were aware of PREA and their legal right to be free from sexual abuse or sexual harassment.

Indicator (c). The Auditor was provided materials in 2 languages. The Auditor reviewed the agency website and information on it's commitment to providing accommodations to individuals with disabilities. A resident with a cognitive disability confirmed there are enough staff available that someone can help you if you have trouble reading. Policy MIL 1.05 requires "Provide client education in formats accessible to all clients, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as clients who have limited reading skills."

Indicator (d). Each resident's intake packet includes a handbook/PREA education acknowledgment form. The resident is required to sign and date the form that is placed in their treatment file. The Auditor reviewed a sample of 22 current and prior resident's forms. The prior residents were randomly sampled over the past 12 months. Resident interviews confirmed the orientation process does occur in most cases within the first hours of their admission. Policy MIL 1.05 confirms the standard expectation, "Maintain documentation that acknowledges that each client received this information and participated with education sessions."

Indicator (e). The Auditor confirmed that residents had handbooks, brochures, and postings (English and Spanish) about PREA and how to report a concern on each level of the facility. Resident Interviews support they were aware of the information even if they said they were not worried about PREA. Policy MIL 1.05 confirms the standard expectation, "Ensure that key information is continuously and readily available or visible to clients through posters, client handbooks, or other written formats. Shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a client."

Compliance Determination
The Auditor has determined Milestone is meeting the standard expectation in policy, practice, and documentation. The random resident Interviews supported all residents of Milestone are provided education related to PREA. Resident interviews supported they know the zero-tolerance expectation toward sexual abuse or sexual harassment. The random residents confirmed that intake staff also educated them on how to report a concern and community-based services for those with victimization histories. Residents confirmed they did receive the information on a timely basis upon arrival. Three policies, MIL 1.04, MIL 1.05 and MIL 1.21 address the requirements of education of residents on PREA. Materials are available in more than one language, and the staff were aware of the translation services available. Residents support they understand their rights under PREA and know where to turn for information if needed. The Auditor also considered the documents found in client files consistent with policies supporting PREA education has occurred in determining compliance. The Auditor did require the agency to provide the handbook and the acknowledgment form in Spanish to be consistent with another posting to provide equal access. The agency was able to translate the information requested utilizing a professional agency.

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☐ Yes ☐ No ☐ NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.234 (c)

- 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 administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Reviewed the training materials on Administrative Investigations of Sexual Assaults
Documentation of the individuals who completed the course.

Individuals interviewed/ observations made.
Staff trained to investigate sexual assault or sexual harassment claims

Summary determination.
Indicator (a). Milestone and CHR would not be responsible for completing criminal investigations. The Putnam Police Department would have the primary responsibility for completing criminal investigations at Milestone. The funding source and referring authority of the clients involved would also be informed of any PREA related investigations. The agency has trained 2 staff in completing an administrative investigation in a reentry facility. The agency has used training based on the PREA Resources Center's training on completing administrative investigating of sexual assault in a confinement setting.

Indicator (b). The agency developed a training utilizing available materials on-line resources including ones developed by the Moss group for the PREA Resource Center.. The training provides the individual with the required content of the standard indicator. The information includes; interviewing techniques with victims of sexual abuse, what is a Garrity or Miranda warnings, the importance of sexual abuse evidence collection in a confinement setting, and the factors used in substantiating a finding in an administrative or criminal case. The Auditor reviewed the course to ensure the course content met the standards obligations. As a private "at-will" employer Garrity does not apply, and the agency staff would only be responsible for conducting an administrative investigation. Investigative staff interviewed were aware that if an administrative investigation had unveiled a potential criminal act that the event is immediately referred to the police.

Indicator (c). The Community Health Resources has provided the Auditor with documentation of those who completed the training for investigators. The Agency has 2 staff who have completed the training with others expected to complete it in the coming months. The Auditor spoke with the Service Director on the content of the training and the need to train key agency staff members on completing the administrative investigation. The Service Director understood preponderance of evidence will be the rule for determining substantiation. The investigators from CHR would only be responsible for completing administrative investigations of staff misconduct or investigation of a client-on-client incidents that are clearly not criminal in nature.

Indicator (d). The Auditor is not required to audit this provision.

Compliance Determination
The Auditor initially found the standard not to be in compliance. The agency did not currently have any individuals trained in the completion of administrative Investigation in a correctional setting. Previously

the agency was led to believe the standard did not apply because they were not a correctional center. The Auditor did review the standard's expectations and did determine the agency would complete some form of administrative investigation into staff actions anytime there was a criminal investigation. The Auditor also confirmed the facility does not rely on other state agencies to investigate PREA allegations that are not criminal in nature. During the post audit period, the agency developed specialized training to be in compliance with the standard. Absent any allegation of sexual misconduct, the Auditor relied on agency policy, training materials, interviews with the Human Resources Director, the Vice President of Adult Services, the Service Director, and Milestone leadership in determining compliance. The agency has taken the appropriate steps to ensure there are trained investigators. The agency was responsive to the Auditor's request and produced comprehensive training based on standards and national resources.

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.235 (a)

- 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.)
  ☒ Yes ☐ No ☐ 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.) ☒ Yes ☐ No ☐ 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.) ☒ Yes ☐ No ☐ 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.)
  ☒ Yes ☐ No ☐ NA

115.235 (b)

- 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.) ☐ Yes ☐ No ☒ NA

115.235 (c)

- 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.) ☒ Yes ☐ No ☐ NA

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 Community Confinement Standards PREA
Agency Training Requirements

Agency specialized training developed of medical and mental health staff.

Individuals interviewed/ observations made.
Service Director
Clinical Staff
Medical staff

Indicator Summary determination.

Indicator (a). During the pre-audit period, it was determined the facility had not had specific training regarding working with victims of sexual abuse as medical and mental health staff. All clinical staff were receiving the agency PREA training and have other training such as trauma-informed practices that may apply. The Service Director researched appropriate training materials for working with victims of abuse. Since the agency does not perform forensic examinations, they created an informative training program to help Medical and Mental Health staff work with victims of sexual abuse in crisis and support them immediately after returning from a forensic examination. The training used was developed utilizing information from The PREA Resource Center and the National Commission of Correctional Health Care. The Video-based training was done over four modules covering an overview of PREA, detecting and assessing abuse, preserving evidence, responding professionally to victims of sexual assault, and reporting abuse and the PREA standard expectations.

Indicator (b). The indicator is NA. Milestone Medical staff will not complete forensic examinations.

Indicator (c). The Service Director provided documentation on the training during the post-audit period. The staff were required to take a test based on the materials that were presented. 5 medical and Mental Health staff completed the specialized training.

Indicator (d). The Medical and Mental Health staff at Milestone complete the facility's regular PREA training that all staff at the facility receive. The training contains information on the agency's Zero-Tolerance toward any sexual abuse or sexual harassment of its clients. The training was developed by Connecticut's Judicial Branch and covered the required topics as noted in standard 115.231. Staff records reviewed to support the completion of these pieces of training.

Compliance Determination

Milestone was able to come into compliance with the standard expectation. The Agency created specific training on working with individuals who are victims of sexual abuse from a clinical and medical perspective. The Service director provided training materials and documentation of the staff who completed the course. The Auditor finds the standard is compliant based on the materials presented. The agency is in the midst of replacing the facility nurse and the Service Director confirmed the new employee will complete this course when they are on boarded along with the basic PREA training.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.241 (a)

- 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 ☐ No
- 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 ☐ No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility? ☒ Yes ☐ No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.241 (d)

- 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 ☐ No
- 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 ☐ No
- 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 ☐ No
- 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 ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.241 (e)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.241 (f)

- 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 ☐ No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

- 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 ☐ No

115.241 (h)

- 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 ☐ No

115.241 (i)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.04 Admission Process
Policy GCC 1.05 Intake Process
Policy MIL1.05 PREA Community Confinement standards

Policy MIL 1.21 Safety and Security PREA
Policy GCC 3.05 Supervisory review of clients at Risk
Policy PHI 4.00 Confidentiality of Client Records
Milestone case files
CHR Risk of Sexual Victimization or Abusiveness tool.

Individuals interviewed/ observations made.
PREA Coordinator
Service Director
Clinical Director
Intake Clinician

Indicator Summary determination.

Indicator (a). All residence admitted to Milestone House are direct admissions from the community. Transfer within the CHR system would be rare. Policy MIL 1.04 requires all admissions to be screened upon admission. The intake clinician does several screenings with clients, including mental status exam, trauma history, legal history, and the agency's screening of clients for risk of being a victim or perpetrator of sexual violence. The Auditor reviewed files of clients admitted one year prior and file of current admissions. All files reviewed confirmed that the residents were screened for victimization and abusiveness within the first 24 hours. Interviews with residents support the screening process is done upon admissions.

Indicator (b). Milestone policy 1.05 requires compliance with the standard when it states, "All clients shall be assessed during an intake screening for their risk of being sexually abused by other clients or sexually abusive toward other clients. The intake screening shall ordinarily take place within 72 hours of admission into the program. Information from the risk screening shall be used to inform program assignment to keep separate those clients at high risk of being sexually victimized from those at high risk of being sexually abusive." The Auditor reviewed 22 admissions over the previous year; all PREA screenings were completed in the first 24 hours after admission. Interview with the Clinician who does screenings and a review of the form sets the higher standard of screening within the first 24 hours.

Indicator (c). The PREA screening tool used at Milestone is broken into two sections, one looking at victimization potential and the other looking at predatory behaviors. All residents are scored with the designation as either a known victim, a potential victim, or a non-victim. Similarly, all residents are given a designation as a known predator, a potential predator, or a non-predator. The Auditor reviewed with the Intake Clinician the process by which the tool is completed. During the screening process, residents are asked a series of 16 questions that cover the standard's requirements. Depending on the resident's answers, direct observation, and information obtained through the file review, the screener scores each category either yes or no. Utilizing the number of yes answers in each section determines the resident's level of risk of being a victim or perpetrator of sexual violence. If the facility is provided with treatment records or probation studies, these additional sources will be considered along with the client's self-report

Indicator (d). The Intake Clinician confirmed, consistent with policy and the CHR screening tool, elements of indicator d) are all considered in determining a score. The following elements are included: if the resident has been a prior victim of rape or sexual assault, if they are significantly younger or older than the population (U23 or O65), if the physical stature of the individual is smaller than the average population, if the individual has any physical, developmental or mental health issues, if the resident is (or is perceived to be) LGBT or gender non-conforming, has a prior history of sexual abusiveness, has a prior criminal history, history of incarceration, has a history of protective custody and finally, if the resident perceives that she would be at risk in the institution.

Indicator (e). The PREA Screening tool also looks for predatory factors, including a history of predatory sexual behaviors in an institutional setting, a history of physical or sexual abuse toward adults or children, a current gang affiliation, a history of extortion of others, and a history of violent criminal behavior.

Indicator (f). At Milestone, the clinical team is continually reassessing clients' needs and functioning in the program over the 28-day stay. As a trauma-informed environment and a treatment program, clients are able to share issues during treatment, including any concerns of safety. The facility will complete a full reassessment of residents when there is additional information obtained that would impact the screening or if the client is going to stay beyond the 28 days. Clients undergo a minimum of one individual session per week along with a full group treatment regimen. Weekly Treatment team meetings allow for additional information to be communicated about the client's progress in the environment. Clinical staff routinely ask residents about their perception of safety. The clients report the treatment environment is supportive.

Indicator (g). The Clinical Director and the Intake Clinician are aware that reassessments should occur whenever appropriate information is obtained that might impact a resident's scoring. Reasons for additional screenings can be new information that has been obtained supporting aggressive or victimization histories, behavioral observations, or actual incidents related to sexual abuse or sexual harassment in the facility.

Indicator (h). The Auditor confirmed with an Intake Clinician that at no time would residents be disciplined for failing to answer questions related to their physical or mental disabilities, their victimization history, their sexuality, or being perceived as LGBTI.

Indicator (i). Through interviews with the Service Director and the Intake Clinician, the Auditor confirmed that PREA sensitive information used in the scoring process is kept confidential.
The clinical records are kept in the clients' electronic medical records. The agency has a confidentiality policy PHI 4.00 that confirms clinical staff and medical staff have different access to client admission than the residential counselors.

Compliance Determination

The screening instrument provided an objective scoring process, and the individuals charged with administering it were consistent with the policy on the description of scoring and security of information. The Auditor reviewed 22 case files to confirm the screenings' timeliness and confirmed the screening

process was applied consistent with the described procedures. The agency's tools were consistent with the standard elements. As a result of the interviews with staff, policies provided, completed scoring forms, and interviews with residents supporting screening and reassessments, the Auditor has determined the standard is compliant.

Standard 115.242: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.242 (a)

- 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 ☐ No
- 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 ☐ No
- 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 ☐ No
- 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 ☐ No
- 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 ☐ No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

115.242 (c)

- 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 ☐ No

- 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 ☐ No

115.242 (d)

- 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 ☐ No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.242 (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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL1.05 PREA Community Confinement standards
Policy MIL 1.21 Safety and Security PREA
Resident casefiles

Individuals interviewed/ observations made.
Service Director
PREA Coordinator
Intake Clinician
Residential Supervisor
Random Residents
Random Staff

Summary determination.

Indicator (a). The Milestone administration uses the PREA Screening information to inform housing/ bed assignments and recommendations for treatment. The program does not have an educational or vocational aspect. Milestone uses screening information to identify which bedroom is most appropriate for the resident. The facility will not put known or potential victims in the same sleeping space as those who are known or potential perpetrators of sexual violence. As the program has multiple floors, residents can be provided further separations in the open environment. Each housing area has single rooms that can be utilized to further ensure individuals with perpetrating or victimization histories are housed in the safest manner possible. Residents with prior histories of sexual violence may be offered treatment, but since the program is voluntary drug treatment, there is no requirement to cover the issue in therapy. Agency policy MIL1.21 states, "Room assignments by staff shall ensure a client's potential for victimization or predatory risk has been reviewed through screening tools to ensure placement with any roommate does not pose a risk."

Indicator (b). Milestone's Intake Clinician is responsible for utilizing the screening information to provide the most appropriate housing in each population. The screening instrument helps identify parameters that ensure potential victims are not housed with individuals prone to perpetration. Residents can be moved when needed to ensure the most comfortable setting is possible. All moves of rooms would be approved through facility leadership, who would have knowledge of risk screening results. If needed, the facility can create single room only situations that could be used in transgender or intersex residents' housing. As noted in indicator (a), policy MIL 1.21 sets forth individualized planning expectation based on the individual residents' needs. With different housing floors and rules preventing residents from going in other's rooms, the facility can keep separate individuals who may be likely victims from those with aggressive histories or histories of engaging in sexual relationships in an institution.

Indicator (c). In discussions with facility leadership support, they would make housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis, considering whether a placement would ensure the resident's health and safety and whether the placement would present management or security problems. In discussions with facility leaderships, the Auditor confirmed they would have open conversations with the transgender or intersex resident at referral about the environment, that it is a female population and how housing assignments could allow for privacy and safety if they had a concern. Though much of the counseling work is done in group settings, the leadership shared how they can individualize aspects of the program. One transgendered client previously in the program did not feel comfortable in a weekly support group on sexuality. To resolve her concern, the client was provided different clinical work and met with individually. The Service Director confirmed as a voluntary drug treatment facility, they are able to have a pre-screening call with the individual to talk about the facility and accommodations they can provide.

Indicator (d) As noted in indicator (c), a transgender or intersex resident's own view with respect to her own safety would be given serious consideration. Milestone begins this process at time of referral and will have conversations with the potential client in advance about what to expect. Milestone Management staff confirmed that during the referral period, on the first day in the program and throughout the client's stay in the 28-day program, the Client will be continually assessed for their feelings of safety in the program. MIL 1.21 notes that Transgender clients can be housed in single rooms, and all bathrooms in the program are single person use.

Indicator (e). Transgender or intersex residents referred to Milestone would be housed in one of the smaller rooms to provide the greatest level of privacy. The facility population allows flexibility to accommodate residents with single rooms. All bathrooms in the program are single person use.

Indicator (f). Milestone does not use an individual's LGBTI status as a mechanism to place all similar status individuals together. There is no state law in Connecticut requiring the housing of LGBTI. The Auditor confirmed with random staff that LGBTI residents are not housed together as a practice or requirement.

Compliance Determination
Compliance was determined based on policy language, interviews with screening staff, and case file review. In determining compliance in indicator (f), random staff and residents who identify as LGBTI

confirmed inappropriate housing practices were not utilized. The facility did not currently house any transgender or intersex residents; as such, interviews with these populations could not occur. Interview with the Service Director supports Milestone utilizes the screening information to protect all residents from sexual assault or sexual harassment. Interviews confirm there are weekly case management review meetings where key elements of the screening information or observations of the client's behaviors in the environment are discussed if it impacts screening results. File reviews support screening information is used for housing (including bed assignments) and treatment planning. If there is a conflict between residents, the Auditor confirmed, bed reassignments must be made by the Milestone Residential Supervisor or a clinical team member. This process ensures victims and perpetrators are not together and ensures information about client dynamics learned in weekly case reviews are also considered. In determining compliance, the Auditor relied on the facility's past practice with Transgender residents, interviews with current residents and staff, and the agency and facilities administration stated expectations.

REPORTING

Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- 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 ☐ No
- 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 ☐ No

115.251 (b)

- 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 ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy GAP 1.06 Anti Harassment
Policy GCC 1.02B Residential Consumer Rights
Policy GCC 1.02D Grievance Complaint Procedure
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21 Safety and Security PREA

Individuals interviewed/ observations made.
PREA Coordinator
Service Director

Indicator Summary determination.

Indicator (a). The Community Health Resources and the Milestone facility provides the residents with multiple ways to report sexual harassment, sexual abuse, retaliation, or the neglectful acts of staff that

could contribute to such harassment or abuse. Policy MIL 1.21 (page 15) states, “CHR Milestone shall provide multiple internal ways for clients to privately report sexual abuse and sexual harassment, retaliation by other clients or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents;” Facility brochures, posters, and residents confirm they can tell any staff person, any facility administrator, or the Service Director. The agency has an internal grievance process where a Milestone client could file a complaint to the agency’s Consumer Rights Officer, who is by policy a senior agency administrator. The Auditor confirmed with both resident and staff in interviews on the multiple internal ways an individual may report a concern. Residents were able to give multiple examples, knew they could make anonymous reports, and make reports on behalf of other residents.

Indicator (b). The residents can report any safety concerns to the state’s Department of Mental Health and Addiction Services (DMHAS) which licenses the Milestone facility. Postings show the name and phone number of the DMHAS Client Rights Officer. As a Joint Commission-accredited facility, there is also information about reporting treatment complaints to Joint Commission that would be forwarded back to the agency administration. The Auditor did outreach to the DMHAS Client Rights department to confirm how they would handle a sexual abuse claim and if the resident could remain anonymous. The DMHAS representative confirmed their ability to report PREA Concerns back to the facility and to the local authorities. The DMHAS representative explained how contact could be made to their regional staff directly who are familiar with the program.

Indicator (c). Policies MIL 1.05 and MIL 1.21 require all staff to accept a report of sexual abuse, sexual harassment or concerns of retaliation from any resident or third-party and to report them to the supervisor and document the information. The policy goes on to describe the notification process, including the requirement that the PREA Coordinator and the facility administrators are both notified within 2 hours. Interviews with random staff confirm that they know they must receive and document an allegation of sexual misconduct, no matter the source, immediately. Staff knew the importance of ensuring the documentation confidentiality and written materials should not be in the client files where others may have access.

Indicator (d). CHR provides the staff of Milestone multiple ways in which a staff person can report a concern about PREA in the facility. They are aware they can go outside the chain of command if the supervisor is alleged to be involved in the misconduct. The staff gave examples of different CHR senior leadership they would be comfortable approaching, that they could use the agency’s online reporting process or call the PREA Coordinator. Staff recognized they could report a concern through the agency PREA Coordinator, the Service Director, or to the Human Resources Department.

Compliance Determination
The standard is compliant. The agency and facility have put in place multiple avenues for staff and residents to report concerns of sexual misconduct. The agency PREA Coordinator also confirmed there were no calls from a resident or third-party individuals with concerns of sexual misconduct at Milestone. The Auditor also utilized the agency reporting system through its website and the outside reporting system. Interviews with residents, staff, and agency administration support the necessary resources were in place to ensure a timely response. Residents confirmed they would go to a staff they trust as a primary option if they felt a need to report a concern and believed it would be taken seriously.

Standard 115.252: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.252 (a)

- 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 ☐ No

115.252 (b)

- 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 ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (c)

- 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 ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (d)

- 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 ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond 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 ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (e)

- 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 ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

115.252 (f)

- 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 ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
  ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy GCC 1.02B Residential Consumer Rights
Policy GCC 1.02D Grievance Complaint Procedure

Individuals interviewed/ observations made.
Resident Interview
Staff Interview

Services Director Interview
Consumer Rights Officer Interview

Indicator Summary determination.

Indicator (a). During the PRE-Audit phase, the Service Director and the Auditor discussed that the agency does have a grievance policy that would apply to the standard. The Auditor review the documentation in a previous standard that meets the intent of providing meaningful access to report a concern of sexual misconduct. GCC 1.02B Residential Consumer Rights and GCC 1.02D Grievance Complaint Procedure have language about protecting clients' rights, including being free from sexual harassment. In policy and postings, the clients are told they can report concerns to the Consumer Advocate. The Agency Website also confirms that family members can file on behalf of the clients at Milestone with the victim's permission. An interview with the Agency Consumer Rights Officer confirmed the process in place.

Indicator (b). The policy does not require residents to resolve concerns through an informal process. The policy also states there is no time frame in which any grievance (including PREA) must be filed. Interview with the Service Director confirms the standard's conditions. If the grievance is regarding a criminal act such as sexual abuse, the case is handled immediately. This would include notifications to the Senior Vice President of Adult services and the authorities to complete a criminal investigation into the claim. The Consumer Right Officer is outside the Milestone chain of command and will work with the client and the facility leadership to resolve concerns.

Indicator (c). Grievances at Milestone can be submitted to the Consumer Rights Officer. There are phone numbers provided on the agency Website from which clients can call to make the complaint. Residents report they can use phones in privacy away from staff. The Consumer Rights Officer confirmed there were no PREA related grievances filed in the two years she has held the position.

Indicator (d). Milestone and Community Health Resources policy GCC 1.02D Grievance Complaint Procedure addresses the maximum time frames in which a grievance must be resolved. The time frames include an initial expected response is ten days. The agency can take an extension of an additional 15 days if approved by the Senior Vice President of Adult Services with documented justification. The agency response periods are quicker than the standard which is appropriate for the short-term nature of Milestone. In discussions with the Service Director, it is clear that grievances, in general, do not take that long to be resolved. There have been no grievances in the past year related to sexual misconduct at Milestone.

Indicator (e). Random staff interviewed confirmed that third-party grievances are possible. Staff acknowledged that complaints and/or grievances might be filed by the resident's family members, attorneys, community agencies, or other professionals working with the client. Interviews with residents and staff confirmed there is no formal policy that prohibits a resident from filing a grievance on behalf of another resident or a resident assisting a fellow resident in the preparation of a grievance. Policy GCC 1.02D Grievance Complaint Procedure (page 1) states, "Clients, families, employees or significant others may file a grievance. Any person other than the individual client receiving services may file a complaint on behalf of the client but must have his/her written consent." The policy allows the victim to

have a right to decline the grievance to be processed in a third-party grievance. The PREA Coordinator and Consumer Rights Officer confirmed there were no grievances filed related to any sexual misconduct or retaliation for prior reporting.

Indicator (f). As noted in indicator (b), if the Consumer Rights Officer is aware of a potential criminal act such as sexual abuse, the case would be handled immediately with notification to the Adult division head and the local authorities. Discussions with the Service Director confirmed an immediate response would occur, and if there is any aggression, the individual or individuals would be removed from the program.

Indicator (g). As a treatment facility for substance-abusing adults, the agency has no formal disciplinary process. Clients who engage in aggression would be asked to leave the program.

Compliance Determination

Milestone has not had any cases in which a grievance was filed related to PREA, including any third-party grievance complaints. As a result, there are no grievance files to review in determining compliance with the standard. The Auditor relied on interviews with staff, residents, the Consumer Rights Officer, and the Service Director along with policy reviews to determine compliance. Staff interviewed were aware that they must accept all grievances, including from a third-party. Residents were aware of their rights under the grievance policy.

Standard 115.253: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.253 (a)

- 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 ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.253 (b)

- 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 ☐ No

115.253 (c)

- 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 ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21 Safety and Security PREA
MOU with Sexual Assault Crisis Center of Eastern CT
Resident Handbook

Individuals interviewed/ observations made.
Representative of Sexual Assault Crisis Center of Eastern CT
Service Director
Case Manager
Random residents
PREA related postings in the facility

Indicator Summary determination.

Indicator (a). At Milestone, residents are provided information on accessing services for individuals who may have been the victim of sexual abuse. The residents are provided with brochures and postings from the Sexual Assault Crisis Center of Eastern CT (SACCEC). The Auditor also was able to see information posted about these organizations in hallways, common areas, and case management staff offices. Residents of Milestone have access to a phone on site that is not recorded. Residents

report they are allowed private communication with representatives of these organizations. The Agency has conference rooms that clients can use a phone from without others being present.

Indicator (b). Milestone residents are made aware of all staff members' duty to report any incident of sexual abuse. Residents of Milestone have access to unmonitored communication with outside agencies. The Phone system of Milestone is not monitored. In discussions with Clinical staff, confirmed clients are provided notice related to the limits of confidentiality consistent with state laws. SACCEC, the local rape crisis agency, confirmed the ability to provide confidential support to the resident and provide those support directly at the facility in a non- COVID 19 period. Currently, they can work with the clients through phone support.

Indicator (c). The Community Health Resources have entered into a Memorandum of Understanding with the Sexual Assault Crisis Center of Eastern CT to provide emotional support to victims of sexual assault. The MOU supports they provide trained sexual assault crisis counselors to support victims during forensic examinations or investigative interviews. SACCEC provided free services, including a 24-hour hotline for emotional support and coordination of referral for continuing services after discharge. The MOU was signed in 2018 and is to remain in force until either party decides to terminate the agreement.

Compliance Determination
Residents at Milestone are provided access to outside confidential support services. The residents have access to on-site clinical staff in addition to the services available through the Sexual Assault Crisis Center of Eastern CT. The agency provided documentation that supported the appropriate relationships required in indicators (a) and (c) that exist. Interviews with the Service Director and case management staff confirm how residents can be assisted in making an appointment for counseling. Observation during the tour supported that information about services was available in both English and Spanish. These languages are the two most common languages spoken by residents entering Milestone. Compliance is based on the materials available, the relationships developed with a community provider, and the resident's knowledge of how to access the resources. Further supporting compliance, residents who could not name the rape crisis agency believed that various staff would help them access such services if needed.

Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 PREA Community Confinement Standards
Agency Web Site (third party reporting form)

Individuals interviewed/ observations made.
PREA Coordinator
Service Director
Consumer Rights Officer
Resident Interviews
Staff Interviews

Summary determination.
Indicator (a). Community Health Resources has established systems to receive third-party reports on sexual assaults or sexual harassment. The agency website provides a phone number and information on filing a concern regarding a client's treatment. The agency PREA policy MIL 1.05 and its website speak to the importance of ones dignified treatment. The grievance process states that it is not only for clients to report a concern but also for their family members or significant others in the client's life. Residents are provided information on how to report a PREA concern in their handbook and postings in the facility. The random residents interviewed supported they could make a complaint on behalf of a peer if they were too fearful for some reason. They also reported confidence that the situation would be investigated. Staff interviewed were aware that all third-party complaints needed to be taken seriously and referred immediately to the Service Director and the Agency PREA Coordinator. The Consumer Rights officer can field complaints from family members or other interested parties. The Consumer Rights Officer process works in conjunction with the state Department of Mental Health and Addiction Services. Complaints filed are also reported to DMHAS.

Conclusions:
The Milestone and Community Health Resources have successfully provided multiple means for residents and other interested parties to make a PREA complaint as a third party. The information is publicly available on their website and is provided to visitors as they enter the facility in brochures and postings. The facility has trained the Milestone staff on the need to accept all complaints no matter the source and refer them so they can be investigated. Interview with staff and residents to support the policy expectations are understood. The Service Director, the Consumer Rights Officer, and the agency's PREA Coordinator reported not having received any third party PREA related complaints in the past year. Compliance is based on all the factors listed here, which support multiple avenues to report a concern about Sexual Harassment or Sexual Assault.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

115.261 (b)

- 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 ☐ No

115.261 (c)

- 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 ☐ No

- 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 ☐ No

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, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.261 (e)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.21 Safety and Security (PREA)
Policy MIL 1.05 Community Confinement Standards PREA
Policy GAP 1.16 Incident Reporting
Policy PHI 4.00 Confidentiality of Client Information
Staff PREA Training materials
Connecticut state website on reporting requirements of elder abuse, and disabled individuals
Department of Mental Health and Addiction Services

Individuals interviewed/ observations made.
CHR PREA Coordinator
Service Director
DMHAS Representative
Random Staff

Indicator Summary determination.
Indicator (a). Policy MIL 1.21 Safety and Security (PREA) (pg. 5) requires "All allegations of sexual misconduct or client-on-client sexual activity shall be reported to the PREA Coordinator and/or PREA Facility Compliance Manager (both positions currently held by the Sr. Program Director) within 2 hours." The policy goes on to state, "All staff are required to immediately report any knowledge, suspicion, or information received regarding any incident that has occurred in the facility; retaliation against a client or staff who report sexual misconduct; and any staff neglect or violation of responsibilities that may have contributed to an incident of sexual misconduct or retaliation to the Abuse Registry, local law enforcement, and the PREA Facility Compliance Manager." The staff interviews support they knew they must report all allegations of sexual assault or sexual harassment no matter the source of the allegation or even if they had questions on the validity of the allegations. Staff confirmed the agency expects them to report all actions or inactions of staff that may hay contributed to the abuse.

Indicator (b). Policy MIL 1.21 requires the staff to keep confidential any PREA disclosure except to agency administrators and supervisors to facilitate treatment. Staff in random interviews repeatedly confirmed their awareness of the importance of protecting the victim and the investigative process by limiting the disclosure to those with a need to know. They were also aware of documenting the incident on email or written document to their supervisor but not to put it in the electronic case management system where others could read. Policy MIL 1.21 states, "Apart from reporting to designated supervisors or officials, all staff should only reveal information to those individuals who have a need-to-know basis to make treatment, investigate or other security and management decisions."

Indicator (c). Milestone policy MIL 1.21 states, "Medical, case managers and mental health practitioners are required to report sexual misconduct to designated supervisors and Department officials, law enforcement if criminal in nature, and the Abuse Registry. Said practitioners must inform residents at the initiation of services of their duty to report and the limits of confidentiality." Interviews with residents support they understand the limits of the clinical staff. They knew that risk to self or others must be reported.

Indicator (d). Milestone would not receive a resident under the age of 18. Staff are trained in mandatory reporting laws, and the local police could apply additional charges to crimes against these populations. The state of Connecticut website confirms that residents over the age of 60 and those with disabilities have special protection under the law from sexual abuse.

Compliance Determination
The Auditor concludes the standard is compliant based on training materials, policy, and interviews completed. Since there were no sexual assaults, investigative file reviews and direct interviews of victims or first responders were not possible. The Auditor spoke with the Service Director, CHR PREA Coordinator, random staff, the nurse, and clinical staff. The Auditor concludes that policy addresses for

staff the need to report all incidents of Sexual Assault or Sexual Harassment while protecting the resident victim's privacy and the investigative process. Further supporting compliance is the interview with the medical and mental health staff, who confirmed that residents of Milestone are educated on the limitations of confidentiality. The Service Director provided a memo on how the standards elements are addressed in daily operations.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.262 (a)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Overall Compliance Determination Narrative

Policies and written/electronic documentation reviewed.
Policy GCC 3.05 Supervisory Review of Risk to self or others
Policy GCC 3.05a Tarasoff Warnings

Individuals interviewed/ observations made.
Senior Vice President
Service Director
Residential Supervisor

Random Staff
Random Residents

Indicator Summary determination.
Indicator (a). Milestone has not had a situation where a resident has needed protective services from substantial or imminent risk of sexual assault. The facility has trained its staff to handle these situations consistent with first responder expectations, including taking immediate actions to ensure safety, keeping them apart from any perceived threat, and notification to supervisory staff. In the past three years, the facility has not had to separate residents as a part of a plan to keep a resident safe from sexual misconduct. As a mental health facility, the agency has policies in place to require immediate actions when a client is at risk to themselves or others. The agency has a duty to report to the potential victim under Tarasofff law any intent of one client to harm another. Staff interviewed were able to clearly describe the steps they would take to protect an individual who had reported a fear until they can be met with by clinical staff.

Compliance Determination
Since Milestone has not had to provide protection duties for a resident in danger of sexual assault, the Auditor relied extensively on interviews to determine compliance. Interviews with the Senior Vice President, the Residential Supervisor and Service Director confirmed multiple steps and would be enacted to ensure all clients' safety. Those steps would include moving the resident's room, identification of the potential threat, investigation, and the possible transfer or discharge of one or the other parties depending on perceived aggression. As a voluntary program, threats of violence are taken seriously and clients can be removed from the program at any time. Random staff who were interviewed stated they would immediately respond to any concern related to residents' safety. The random staff reported they would speak to the at-risk client in a private setting to understand the situation better. After discussing with the resident, they would notify supervisory staff so a solution could be determined. Interviews with random residents supported that they could approach staff with a concern related to PREA and felt it would be addressed.

Standard 115.263: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.263 (a)

- 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 ☐ No

115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.263 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Overall Compliance Determination Narrative

Policies and written/electronic documentation reviewed.

Individuals interviewed/ observations made.
Service Director
CHR PREA Coordinator

Indicator Summary determination.
Indicator (a). Interview with the Service Director, who oversees Milestone, confirms that they would work with the client to report the previous abuse to the facility where it happened. As a treatment center, CT state laws on sexual abuse confidentiality would be the prevailing rules on the ability to report abuse without client permission.

Indicator (b). In the interview, the Service Director was aware that notifications must be made within 72 hours of his staff being made aware of a sexual assault at another institution. The Agency is bound by state privacy laws as the program is voluntary and not part of the correctional system.

Indicator (c). The Service Director of Milestone reports she would document the notification by making a follow-up email after making initial contact with the other facility's Director.

Indicator (d). The Service Director and PREA Coordinator confirmed that an investigation would be enacted immediately upon notice from another institution of any criminal behavior that occurred at Milestone.

Compliance Determination
CHR has not received any reports from other correctional institutions about claims of sexual assaults that occurred at Milestone. The facility did not have to report any claims of sexual assault to any other correctional institution. Compliance, absent a claim that has to be reported to another facility, relied on the Service Director's knowledge of the requirements of the standard, including timeframes for reporting to other institutions. The agency understands the importance of responding to a past allegation of misconduct at their facility. Likewise, the Service Director is committed to a notification to correctional centers when past abuse is reported as allowed within state laws. Milestone is not a correctional center, and It is a drug program that has 2 of 16 beds funded by the Connecticut Judicial Branch.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.264 (a)

- 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 ☐ No

- 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 ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- 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 ☐ No

115.264 (b)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Overall Compliance Determination Narrative

Policies and written/electronic documentation reviewed.
Policy Mil 1.21 Safety and Security (PREA)
Policy MIL 1.22 Coordinated Response to Sexual Assault Incidents
Milestone Coordinated Response Plan
Milestone PREA Training materials
Memo from the director on the lack of incident requiring a First Responder
Agreement with the local hospital to provide SANE services.

Individuals interviewed/ observations made.
Random Staff

Indicator Summary determination.
Indicator (a). Milestone has not had a case requiring a staff member to act as a first responder to a sexual assault or sexual harassment complaint. The Auditor had to rely on random staffs' ability to

explain their first responder responsibilities. The random staff interviewed described the steps that they were trained on, including separating the victim and the potential threat, and securing the crime scene. They also knew to ask both the victim and the accused perpetrator to not shower, wash, brush, eat, drink or take any other actions that would affect the evidence on them or their clothes. CHR Policy MIL 1.22 also sets forth expectation for staff consistent with this indicator, it states, “First Responder will:
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) Request that the alleged victim not take any actions that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating. 4) Immediately contact Supervisor on duty or on-call supervisor and police.” (page 1) The Auditor also confirmed that the accused would also be requested to not brush, eat, drink, wash etc. to preserve evidence.

Indicator (b). All staff at Milestone are trained to be first responders. All staff are trained in the facility’s Coordinated Response Plan. The first four steps of the plan describe the actions that person could undertake in a sexual assault as a first responder. The staff interviews confirmed a consistent understanding of the expectations.

Compliance Determination
As stated above, Auditor had to rely on random staff interviews in determining compliance for the standard. The facility has yet to have a staff person act as a first responder. The Auditor relied on the staff’s ability to describe training expectations. The staff were well versed in the expectations of a First Responder, including the protection of the potential victim and the preservation of evidence, be it a physical space or on an individual. Individual staff also noted that the coordinated response plan could be used as a reference if they were not sure what to do.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.265 (a)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.22 Coordinated Response to Sexual Assault Incidents

Individuals interviewed/ observations made.
Service Director
Random Staff

Indicator Summary determination.
Indicator (a). Milestone has a Coordinated Response Plan available to staff. The plan focuses on the first responder's actions and identified the several other individuals who would be involved in the response both internally and community resources such as the local hospital and the local rape crisis agency. The Auditor encouraged the Service Director to expand on the information. She rewrote the plan with a more significant description of staff and agency administration duties if there was an allegation of sexual abuse. Agency policy, in which the plan lives, provides improved guidance to staff beyond the first responder, including a more descriptive explanation of the medical and mental health teams' role.

Compliance Determination
The plan is available to all staff and is contained in a policy specifically to address responding to sexual abuse incidents. The staff awareness of the plan at time of the site visit supports compliance and agency practice will ensure that staff receive an update on the policy changes. The Auditor believes that Milestone staff are sufficiently trained in the implementation of the plan if an incident occurs. The Service Director further supported compliance through the expansion of the information and roles of the various members of the response team. These changes were made during the post-audit phase and approved through the agency administration.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.266 (a)

- 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 ☐ No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Overall Compliance Determination Narrative

Policies and written/electronic documentation reviewed.
Employment Application
Policy GAP 6.0 Progressive Discipline

Individuals interviewed/ observations made.
Senior Vice President of Human Resources
Service Director

Indicator Summary determination.
Indicator (a). Community Health Resources, the parent organization of Milestone, does not employ unionized employees at its Milestone facility. The agency's Human Resources Director confirmed the

ability to place staff out on administrative leave during a criminal or administrative investigation into sexual abuse. Agency policy 6.0 states, “CHR recognizes that there are certain types of employee issues that are serious enough to justify an unpaid suspension for investigative purposes, consistent with federal, state and local wage-and-hour employment laws. “

Indicator (b). The auditor is not required to audit this provision.

Compliance Determination:
The Auditor finds the standard to be compliant. The agency has an employment policy that allows Milestone to put an accused staff person out of work on administrative leave. In doing so, they would be able to protect a resident from any further abuse or subsequent harassment. Interviews with Community Health Resources and Milestone leadership and the stated policy supports the compliance determination.

Standard 115.267: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.267 (a)

- 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 ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.267 (b)

- 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 ☐ No

115.267 (c)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 housing changes? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.267 (e)

- 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 ☐ No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 Community Confinement Standards (PREA)
Policy PHI 3.06 Retaliation

Individuals interviewed/ observations made.
Service Director
PREA Coordinator
Senior Vice President

Indicator Summary determination.

Indicator (a). Policy PHI 3.06 Retaliation establishes the agency's expectation for a client to be free from retaliation. It states, "No individual shall be subject to any intimidation, threats, reprisals, coercion, discrimination or other retaliatory actions for exercising their privacy rights." The Service Director reports she would expect the client's clinician to be the facility's primary individual responsible for monitoring any negative outcomes after a claim has been made. If the allegation was against a staff the Clinical Director would be tasked with meeting with the client. The facility did not have any sexual abuse or sexual harassment cases requiring monitoring.

Indicator (b). The Service Director and the Senior Vice President both spoke to the multiple options Milestone has to protect residents from retaliation. This includes reassigning rooms or moving residents from one floor to another. In more extreme cases, the agency may ask an aggressive resident to leave the program. The Auditor confirmed that the client may also be moved to rooms closer to staff offices and additional check-in with mental health would occur.

Indicator (c). The Milestone facility has not had a PREA related complaint that would require the monitoring of residents or staff. The Service Director was aware that staff and residents who report or

cooperate with a PREA investigation should be monitored for a period of up to 90 days (Milestone is only a 28-day program). She was able to describe things that would be reviewed as a possible symptom of retaliation. Examples include monitoring changes in attitude or behaviors, changes in interactions with peers.

Indicator (d). The Service Director reports there would be periodic check-ins made to any individual who cooperated in the investigation. By practice, Milestone Clinical staff routinely asked residents about their feeling of safety.

Indicator (e). As noted in indicator (b), the protections enacted by Community Health Resources would extend to any individual who cooperated in the investigation of sexual misconduct.

Indicator (f). The Auditor is not required to audit this provision

Compliance Determination

The Auditor finds that Milestone is compliant with the expectations of this standard. The Service Director and the Senior Vice President are both aware of the conditions they need to monitor for retaliation against any individual who cooperates in an investigation. The program's short-term nature would limit the duration of the client retaliation monitoring to only the time allotted in the program under a month. Supporting this determination of compliance was the policy statement, the counseling services available to staff and residents, and the interview results. Included in consideration were the residents who consistently supported they could approach any staff and believed they would be kept safe.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.271 (a)

- 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 ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.271 (b)

- 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 ☐ No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

- 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 ☐ No

115.271 (e)

- 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 ☐ No
- 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 ☐ No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No
- 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 ☐ No

115.271 (g)

- 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 ☐ No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.271 (i)

- 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 ☐ No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- 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 administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.21 Safety and Security (PREA)
Policy MIL 1.05 Community Confinement Standards PREA
Administrative Investigation Trainings

Individuals interviewed/ observations made.
Service Director
PREA Coordinator
Putnam Police representative

Summary determination.
Indicator (a-j). During the pre-audit phase, the Auditor discussed how the standard applies to the Milestone program with the Service Director. The agency is not responsible for completing criminal investigations at Milestone. The Agency has a working relationship with the local Putnam Police Department as well as the local State Police Barracks who have the legal authority to complete criminal investigations into sexual assault. Since it was determined that the program handles investigations into non-criminal sexual misconduct claims and completes its own investigations into staff actions during critical incident reviews, there needed to be training completed, as noted in 115.234.
The facility staff are trained on how to protect evidence by sealing off the area until trained police investigators arrive and by encouraging the reported victim and perpetrator not to change, wash, brush, drink, smoke, etc. in an effort to preserve evidence. Staff were aware they needed to file reports, and the agency administration will support the criminal investigation by sharing documents allowed by law.
As the Milestone and CHR staff are not responsible for criminal aspects of the case, compelled interviews and communication with prosecutorial authorities would remain the police's responsibility.
The Auditor confirmed with the local Police that Polygraph or other truth-telling devices are not required to move forward in the investigative process.
Though Milestone staff have not completed an administrative investigation into sexual abuse or sexual harassment allegations, they have in place the pieces to ensure that all claims are investigated. The Agency staff confirmed they would look into staff's actions or inactions to determine if they allow the abuse or harassment to occur.
The CHR PREA Coordinator would retain all investigative reports related to any PREA incident. The agency policy requires retention for a period of 10 years after an individual has left the facility.
The Service Director was aware that the departure of an alleged abuser or victim would not result in a premature conclusion of the administrative investigation.

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

Indicator (l) Milestone has a working relationship with the Putnam Police Department. The Service Director reported that she would ensure open communication between the two agencies so that federal requirements of PREA, including required notifications can be completed in a timely fashion.

Compliance Determination
There was no individual who was a reported victim of sexual assault at Milestone for the Auditor to interview as part of this standard's review. Absent a criminal case or administrative; the Auditor relied on interviews, policy, and training materials to determine compliance. As a 28-day substance abuse program, it is likely that the perpetrator of sexual assault or sexual harassment would be removed from the facility. It is also likely the victim would be released before a criminal investigation or indictment would occur. The agency has taken the appropriate steps to be prepared to complete and document administrative investigations into sexual abuse or sexual harassment claims.

Standard 115.272: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.272 (a)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Administrative Investigation Training.

Individuals interviewed/ observations made.
Service Director

Indicator Summary determination.

Indicator (a). As noted in standard 115.234, the agency did not have an individual at Milestone or at CHR who had completed the specialized training on administrative investigations. The agency has had no allegations of sexual abuse or sexual harassment in the past year. Subsequent to the site visit, the agency has completed the training of 2 staff in preparation for the ability to investigate sexual abuse or sexual harassment claims in an administrative investigation. The Intention is to add additional trained staff over the coming months.

Compliance Determination
The Auditor spoke with the Service Director as the Investigator. CHR has trained Milestone and agency leadership in completing administrative investigations of PREA claims of sexual abuse or sexual harassment. The Auditor confirmed there is no greater standard in determining the investigation outcome than a preponderance of the evidence. The agency training materials also supports a determination of compliance.

Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

- 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 ☐ No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.273 (d)

- 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 ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.21 Safety and Security (PREA)
Policy MIL 1.05 Community Confinement Standards PREA

Individuals interviewed/ observations made.
Interview with Service Director
Interview with PREA Coordinator

Indicator Summary determination.

Indicator (a). After an investigation, Milestone Administration will ensure, according to interviews, that resident victims are informed of the outcome, including a determination that the claim is substantiated, unsubstantiated, or unfounded. The notifications of the criminal cases' outcome will be done by the investigation authority or the state's victim advocate. The facility would meet with clients on administrative investigations into non-criminal claims.

Indicator (b). As noted in 115.271 (l), if Putnam Police Department is completing the criminal investigation, the policy (MIL 1.21) expectation is 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 Service Director would open up communication channels to ensure sufficient information is obtained in a timely fashion to report to victim residents. CHR would complete administrative investigations of sexual assault where appropriate. Such investigations would be looking if the staff's actions or inactions played a part in the assault. Absent a case of sexual misconduct, the Auditor asked the Service Director about how non-PREA criminal investigation communication occurs between the Putnam Police Department and Milestone.

I**ndicator (c).** As noted in standard 115.266, the agency is committed to ensuring victims and staff alleged to have committed sexual misconduct are separated. The appropriate staff shall determine if the staff member should be placed on administrative leave pending the conclusion of the investigation. The agency has policies in place to be able to place staff out on administrative leave. The Service Director is aware of the required notifications to the victim if an allegation involves a staff person

including when the staff person is no longer employed, has been indicted, or when the staff person is convicted.

Indicator (d). The Service Director is also aware of notification to a victim when a resident perpetrator has been indicted or convicted. Since Milestone length of stay is usually under a month, notification on convictions would be unlikely and become the responsibility of the Victims' Advocate Office of the court house where the case was held. The Service Director was also aware of notification to residents when the accused perpetrator is no longer working at that location if they were indicted or if the staff person was convicted.

Indicator (e). The notification would be documented in the client's chart. The Auditor suggested the development of a form the client signs to ensure consistent application of the notification standards.

Indicator (f). The auditor is not required to audit this provision

Compliance Determination
The Community Health Resources has put in place mechanisms to ensure residents are told of the outcome of sexual assault and sexual harassment claims. In determining compliance, the Auditor reviewed policies, conducted interviews with the Service Director who oversees the Milestone facility, a local police representative, and reviewed the agency's new training on investigating sexual abuse and harassment claims. Milestone had not had a sexual assault or sexual harassment case from which the Auditor could review information.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.276 (c)

- 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 ☐ No

115.276 (d)

- 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 ☐ No

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy GAP 6.0 Progressive Discipline
Policy GAP 1.06 Anti-Harassment Including Sexual Harassment
Policy MIL 1.05 Community Confinement standards (PREA)
Policy MIL 1.21 Safety and Security PREA
Employee application

Individuals interviewed/ observations made.
Service Director
Human Resources Vice President

Indicator Summary determination.
Indicator (a). CHR Policy MIL 1.21 Safety and Security PREA states staff can be subjected to "Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies." Policy GAP 1.06 Progressive Discipline further informs staff of potential discipline when it states, "Although employment with the agency is based on mutual consent and both the employee and the agency have the right to terminate employment at will, with or without

cause or advance notice, the agency may use progressive discipline at its discretion." No employees of Milestone have been disciplined for sexual harassment or sexual abuse of clients.

Indicator (b). CHR Administration is committed to ensuring client safety. As noted in indicator (a), multiple policy languages support employee termination who engage in sexual abuse. Human Resources Director and the Service Director confirmed that employees who engage in sexual misconduct with a resident can be terminated for the first offense. The agency notifies all employees at point of hire on the agency's status as an at will employer with the ability to terminate employees at any time. The employment application directly states this information.

Indicator (c). Community Health Resource is an at-will employer and has the ability to determine appropriate sanctions for non-criminal behavior. Policy GAP 6.0, defines the ability to utilize progressive discipline for employees' actions, which may not be criminal. The policy informs the reader that the agency retains the right to utilize progressive discipline and where steps can be skipped. The language support the standard expectation that 'consequences should be commensurate with the nature of the offense and the employee's history with the agency'. All CHR employees are at-will, which means they may be terminated at any time and for any reason, with or without advance notice. Employees are also free to quit at any time. Interviews confirmed that discipline for non-criminal behaviors would be based on the employee's overall history and the nature of the offense.

Indicator (d). The facility will notify the Putnam Police Department of all sexual assaults or sexual harassment behavior that appears to be criminal in nature, even if the employee has left the agency. The Service Director confirmed that outcomes of administrative or criminal investigations related to sexual abuse or sexual harassment of clients would be forwarded to Human Resources to become part of their employment record. The Agency policy MIL 1.21 states the individuals 'who engage in sexual abuse are 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.' The Human Resources Director confirmed the executive management team would review violations of the agency's code of conduct to determine if the violation warranted notification to the Department of Public Health, who oversees individual licensure of clinical staff. All incidents of sexual misconduct by staff are required to be reported to the DMHAS who licenses the facility

Compliance Determination

The Community Health Resources has a policy that states staff who violate agency sexual abuse or sexual harassment policies are subject to disciplinary action (MIL pages 8-9). Disciplinary actions, up to and including termination, will be taken for a substantiated finding of sexual abuse. Discipline, per policy, will be proportional to the nature and circumstances of the acts committed and comparable to other staff with similar histories. CHR requires all allegations of sexual abuse to be reported to the local authorities regardless of whether the staff resigns or is terminated.

No Milestone staff has been disciplined for a PREA related violation in the past year because of a criminal or administrative investigation. Absent a recent staff discipline, compliance was based on policy and the interviews with the Service Director, the agency PREA Coordinator, and the Human Resources staff. The Auditor also considered interviews with staff who knew the discipline practices of the agency.

Standard 115.277: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.277 (b)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policies and written/electronic documentation reviewed.
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21 Safety and Security PREA
Policy MIL 1.21 Safety and Security PREA
Individuals interviewed/ observations made.

Service Director

Indicator Summary determination.

Indicator (a). Milestone does not employ any individual contractor to provide direct service to residents in the licensed capacity. The facility has no direct service contractors; all contractors entering the facility are supervised by staff. Policy MIL 1.21 Safety and Security PREA allows for the immediate cessation of visits by any contractor or volunteer accused of engaging in sexual misconduct. The agency policy requires all criminal behavior to be reported to the police no matter if the individual is an employee, a contractor, a volunteer, or a visitor. The policy states, “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.”

Indicator (b). According to CHR and Milestone policy MIL 1.21, in the case of any violation of boundary issues by any contractor or volunteer, the Service Director will determine if the violation is non-criminal actions that should result in the termination of their contact with residents. The policy states, “The program 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.” Though there is no current contractors or volunteers, the Service Director confirmed the individual would have an immediate termination of access to residents during the investigation.

Compliance Determination
Milestone does not employ contractors who provide direct services to the clients at the facility. Milestone House does not currently have any volunteers and only one college intern. As noted in 115.232, all individuals entering the facility are educated about PREA, and Contractors or volunteers are supervised. The facility has not employed or received any voluntary services of a professional to whom a licensing board would be informed for violations of PREA. The Agency PREA Coordinator reports that no volunteer or contractor was the subject of any PREA related investigation in the past year or required any corrective actions. Compliance, absent any discipline of volunteers or contractors, is based on policy and interviews with the Service Director and the agency PREA Coordinator.

Standard 115.278: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.278 (a)

- 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 ☐ No

115.278 (b)

- 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 ☐ No

115.278 (c)

- 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 ☐ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.278 (e)

- 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 ☐ No

115.278 (f)

- 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 ☐ No

115.278 (g)

- If the agency prohibits all sexual activity between 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 ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policies and written/electronic documentation reviewed.
Policy GCC 3.05 Supervisory Review of Client at Risk
Policy MIL1.05 PREA Community Confinement Standards
Resident Handbook

Individuals interviewed/ observations made.
Service Director
Representative of Referring Agency
Residents

Indicator Summary determination.

Indicator (a). The Milestone policy MIL 1.05 states, "Clients shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the client engaged in client-on-client sexual abuse or following a criminal finding of guilt for client-on-client sexual abuse." Because the program is a drug treatment facility and a relatively short program length client would likely have been discharged prior to the completion of a criminal or administrative investigation. In policy GCC 3.05 Supervision of Clients at Risk, the agency has in place a mechanism for expedited multi-disciplinary team reviews. The Service Director reports that clients who are abusive or aggressive would be asked to leave the program.

Indicator (b). Policy MIL 1.05 say "Sanctions shall be commensurate with the nature and circumstances of the abuse committed and the client's history. The Service Director reports that the program would look at treatment plan modifications to address other sexual misconduct that might not be criminal in nature. The resident handbook outlines prohibited behavior. Decisions on how to handle non-criminal sexual misconduct would be based on the client's treatment history and overall progress in the community. Since there were no cases of sexual misconduct by residents, there is no documentation to review.

Indicator (c). As noted in indicator (b) all reviews of client misconduct that did not lead to immediate dismissal from the program would be reviewed through the treatment lens and take into consideration the client's prior history and the ability for the overall safety of all the clients. An interview with the

Service Director confirms that the agency and facility have multiple levels of review to ensure decisions are made with the client's treatment in mind and the overall safety of the milieu.

Indicator (d). As a voluntary substance abuse program, perpetrators of sexual abuse would not stay in the Milestone facility after an attack.

Indicator (e). The Auditor also confirmed with the Service Director that residents who engage in sexual relations with a staff would be reviewed through the treatment program.

Indicator (f). As noted in previous indicators, the Milestone facility would approach an intentional false PREA claim through the treatment process. The client's progress in the environment and an understanding of the underlying behaviors are just a few of the issues considered.

Indicator (g). Milestone prohibits sexual contact between residents. It is stated in the resident handbook as part of zero tolerance statements, and residents are aware of this expectation. According to the Service Director, if residents have engaged in sexual activities, there would be an investigation of facts, and residents would be met with to ensure there was no intimidation by either party to claim the activity as consensual. Residents would be not be disciplined but an assessment by the treatment team would be made to determine if the residents can remain in the facility.

Compliance Determination:
Clients of Milestone are taught the program's core values of Safety, Trustworthiness, choice, collaboration, and empowerment. The Client handbook makes it clear "verbal or physical abuse/ aggression/altercations are unacceptable and may lead to discharge" Compliance is determined through the various documents provided and the interviews with the Service Director and random clients. Since Milestone is not a correctional facility and it is only a 28-day program, there is no formal sanctioning process. Individuals who engage in criminal behavior would be removed. Those individuals who engage in sexual abuse would be removed from the program immediately. Individuals who engage in non-criminal sexual misconduct would be reviewed through a treatment lens by the facility's treatment team. The Agency has in place a quick response plan to ensure agency leadership is involved in any decision to remove a client from the program. The Auditor believes the system in place ensures an equitable practice for all clients. Discussions with Facility and Agency leadership supports an effort to ensure the overall milieu safety.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.282 (a)

- 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 ☐ No

115.282 (b)

- 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 ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.282 (d)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policies and written/electronic documentation reviewed.
Policy GCC 3.05 Supervisory Review of Client at Risk MA Dept of Public Health Website
CT General Statutes
CT Technical Guidelines for Health Care Response to Sexual Assault

Individuals interviewed/ observations made.
Representative of Day Kimball Hospital
Representative of the Windham Hospital
Residential Supervisor
Program Nurse
Service Director

Indicator Summary determination.

Indicator (a). Milestone has in place emergency medical treatment for victims of sexual abuse. The facility is less than a mile to the closest hospital and a second hospital with SANE services is 20 miles away. The facility has a nurse and a Medical Doctor on-site part-time. In the interview with the program nurse, she confirmed that they have medical autonomy to determine if a client needs to go out to the hospital. Discussions with the Residential Director also confirm that there are no barriers to getting a client out to the hospital if needed. She reports a victim of sexual abuse would go by ambulance to the local hospital. Since it is an open environment and not a correctional center, there is no security concern when a client can go out to a hospital. The facility coordinated response plan requires potential victims to be sent to the hospital. Also, the local rape crisis agency Sexual Assault Crisis Center of Eastern Connecticut (SACCEC) would also aid the victim at a hospital. Ongoing support for medical support for victims of abuse can occur at the program or in the community at their local service provider. On the first day, the Auditor was on-site, one staff person was taking clients to dental appointments in the client's home community. Agency policy 3.05 covers language if the Mental Health provider believes the client needs to be hospitalized.

Indicator (b). Milestone does not employ medical or mental health staff on a 24 hour/ 7 day a week basis. As such all staff are trained as first responders. In their interviews, random staff were aware of the need to preserve evidence and the importance of supporting the victim emotionally. Milestone has a coordinated response plan that confirms this practice. Interviews with staff further confirmed the importance of an immediate response to both actual sexual abuse incidents and in any situation where residents state concern of potential abuse. The staff described the importance of providing physical and emotional safety to the victim and the importance of immediate access to hospital care.

Indicator (c). Interviews with local hospital representatives supported that resident victims would be offered information on emergency contraception and prophylactic medication. After the emergency visit to the hospital, they may do follow-up care with the program nurse or with their local medical provider if preferred. State Statutes also address these requirements.

Indicator (d). Interview with community service providers and information on the Connecticut protocol for Sexual Assault Investigations confirmed is no cost for the treatment of victims of sexual assault. The state Victim Compensation Fund provides the funds. The statement which is from Connecticut state

statutes SEC. 19a-112a includes No costs incurred by a health care facility for the examination of a victim of sexual assault, when such examination is performed for the purpose of gathering evidence as prescribed in the protocol, including the costs of testing for pregnancy and sexually transmitted diseases and the costs of prophylactic treatment as provided in the protocol, and no costs incurred for a medical forensic assessment interview conducted by a health care facility or provider or by an examiner working in conjunction with a multidisciplinary team established pursuant to section 17a-106a or with a child advocacy center, shall be charged directly or indirectly to such victim. Any such costs shall be charged to the Forensic Sex Evidence Exams account in the Judicial Department.

Compliance Determination
Milestone has available medical and mental health staff onsite or on call. Clients who are victims of Sexual abuse will be sent to a community hospital for forensic examinations. There the client can be supported by Rape Crisis Agency staff. As a clinical setting, all clients are provided mental health services. As a result, they have trained all staff experienced in working with individuals who have prior trauma, including past sexual abuse. Interview with the medical staff confirmed they can support a resident medically post release from the hospital. Clients may also seek medical support from their own primary physician and will be transported by the program. All staff are aware of the importance of protecting evidence, including informing resident victims not to take any action that would degrade evidence. Victims of sexual assault at Milestone have appropriate access to medical and mental health services without cost. The Auditor finds the standard to be in compliance. Absent a case of requiring the implementation of the coordinated response plan, the Auditor relied on policy, staff, and information from community resources in determining compliance.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.283 (a)

- 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 ☐ No

115.283 (b)

- 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 ☐ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.283 (d)

- 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.*) ☒ Yes ☐ No ☐ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.283 (g)

- 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 ☐ No

115.283 (h)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policies and written/electronic documentation reviewed.
PREA Screening results
State of CT Website
CT Guideline for Healthcare Response to Victims of Sexual Assault

Individuals interviewed/ observations made.
Residents with prior victimization histories
Clinical staff
Agency Nurse
Local rape crisis agency
Local Hospital

Indicator Summary determination.

Indicator (a). Milestone will offer medical or mental health evaluations and treatment as needed to individuals sexually abused either at the facility or during a previous institutional stay. A resident who reports prior victimization history to Milestone would be offered the opportunity to cover this trauma during the therapeutic treatment sessions. All clients are screened by both members of the clinical team and the medical team. Absent a case of abuse, the Auditor relied on interviews with the Milestone Clinical Director and the facility's registered nurse. Both reported treating clients in the program who have experienced abuse in other settings. Identified residents with victimization histories interviewed confirmed the access to counseling and medical services.

Indicator (b). Representatives of medical and mental health staff confirm they can provide ongoing services to recent victims of sexual misconduct. As a trauma-informed agency, they look to empower clients in the treatment process while providing a safe environment. Medical staff can support a client who was taken out for a forensic exam offering appropriate follow-up services on-site or through referral. The clinical team will work with the client on the issue they feel ready to address to avoid traumatization. Both medical and clinical teams are experienced in helping clients transition to community-based services in the resident area. Once the resident prepares to leave the 28-day program, these agency's clinical and medical staff confirm they will aid in the continuity of services by making referral recommendations close to the community where they will be living. The representative of SACCEC (Sexual Assault Crisis Centers of Eastern CT) also confirmed that individuals with whom

they have provided supportive services would be offered information about the availability of support in the community in which the individual was going to live.

Indicator (c). Milestone is part of Community Health Resources, one of Connecticut's largest mental health service providers. The Clinical staff have low caseloads to be able to provide intensive support to the client during their stay. The medical staff can provide a host of ongoing support and because the program is not a secure setting, clients can be referred out to the specialist if needed. Residents who have medical specialists can keep appointments in the community as staff can transport them to and from the appointment. Policy MIL 1.21 Safety and Security PREA. addresses the standard language, "The facility shall offer medical and mental health evaluations, an as appropriate, treatment of all clients who have been victimized by sexual misconduct. Victims shall also be provided with medical and mental health services consistent with the community level of care."

Indicator (d). The Windam Hospital staff confirmed victims of sexual assault would be offered pregnancy testing.

Indicator (e). The Windham Hospital staff confirmed if the sexual assault results in pregnancy, the victim would receive counseling on pregnancy-related medical services. Given the short-term nature of the program, a pregnancy would unlikely be know before discharge. The nurse confirmed they make routine recommendations for follow up.

Indicator (f). The Windham Hospital staff confirmed Sexually Transmitted Disease testing is provided to all victims of sexual abuse. The Nurse at Milestone also supported they would work with the client who may have initially refused the STD testing or prophylactic medications.

Indicator (g). Treatment services are provided to victims even if they do not name the abuser or cooperate fully with the investigation. Connecticut has state law prohibiting the billing of victims of sexual abuse. The state protocol for forensic examination includes information on how two state agencies are responsible for reimbursing the hospital for care and the state laboratory for processing the rape kit. The Auditor confirmed the law (C.G.S. §19a-112a) through statue review.

Indicator (h). The indicator does not apply as the facility is for only 28 days and any individual engaging in aggressive sexual behavior would be removed from the program.

Compliance Determination
The Community Health Resources are committed to ensuring residents in all their programs have ongoing access to services if they have been a victim of sexual abuse in any criminal justice setting. Agency Policy MIL 1.21 speaks to each aspect of this standard. The agency has appropriate medical and mental health services to support a resident with past victimization history. The facility does not perform forensic examinations so the agency would send the resident out for an examination but would be able to provide ongoing support to the victim upon return. Interview with medical and mental health providers confirmed that resident victims could receive free of charge services, including STD and HIV testing and treatment and pregnancy testing and related services. In determining compliance, the Auditor considered conversations with the local hospitals, interviews with clinical staff, and residents

with victimization histories. The Auditor also completed internet research on the various health service agencies to further support the finding of compliance.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.286 (a)

- 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 ☐ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.286 (d)

- 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 ☐ No
- 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 ☐ No
- 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 ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- 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 ☐ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy GAP 1.16 Incident Reporting
Policy GAP 1.17 Sentinel or Adverse event reviews
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21Safety and Security PREA
PREA Sexual Abuse Incident Review form.

Individuals interviewed/ observations made.
Service Director
Senior Vice President
PREA Coordinator

Indicator Summary determination.

Indicator (a). Policy MIL 1.21 Safety and Security PREA (page 8) set forth the obligation to have a critical review of all incidents of sexual abuse unless the allegation has been unfounded. The policy states, “The facility shall conduct a sexual misconduct incident review at the conclusion of every sexual misconduct investigation or administrative review, including those where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.” There have been no claims of sexual abuse or harassment at Milestone in the past three years. Incident reviews are part of the agency culture which has senior leadership reviewing what they call Sentinel or Adverse Event reviews.

Indicator (b). Policy, “This review shall ordinarily be conducted within thirty (30) days of the conclusion of the investigation by a Review Team.” Without a complaint, the Auditor can only assess the timeliness based on policy language and senior management staff interviews.

Indicator (c). The review team would include the agency and facility management. Policy Mil 1.21 states, “The facility shall create a Review Team that consists of PREA Facility Compliance Manager; PREA Corporate Compliance Coordinator; Upper-level facility management; and Medical official.” The Service Director confirmed all incidents reviewed at the facility level would be multidisciplinary.

Indicator (d). The MIL 1.21 Safety and Security PREA (page 8) defines the elements to be considered by the review team consistent with this indicator's requirement. In addition to the policy, the Auditor was able to see the intended form used to record the information discussed. The Auditor also confirmed with the Service Director and the PREA Coordinator the elements that would be discussed.

Indicator (e). Absent a PREA complaint of sexual assault or sexual harassment; the Auditor relied on the language in Policy MIL 1.21 Safety and Security PREA and interview with facility and agency administration to understand how information from incident reviews would spurn action.

Compliance Determination
Milestone has not had an incident of sexual assault or sexual harassment in the past three years. As a result, the Auditor had to rely on policy and interviews to confirm compliance. Interviews with senior management of the agency and facility support an understanding of the requirements of the indicators. The Interviews also supported an understanding of how critical review could put into action changes in policy or procedures if needed. The Agency shared related policy on agency management of critical incidents that further supports the review process and help put to action necessary changes to address any identified concerns.

Standard 115.287: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.287 (a)

- 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 ☐ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (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 ☐ No

115.287 (d)

- 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 ☐ No

115.287 (e)

- 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.) ☒ Yes ☐ No ☒ NA

115.287 (f)

- 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.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21 Safety and Security PREA
Policy GAP 1.17 Sentinel or Adverse event reviews
PREA Annual report
PREA Data Spreadsheet (did they adopt a report of some type?)

Individuals interviewed/ observations made.
PREA Coordinator
Service Director

Indicator Summary determination.

Indicator (a). CHR collects uniform data on all sexual abuse or sexual harassment claims at Milestone its only facility that is required to complete a PREA audit. The Auditor was provided with PREA data collection sheet which includes some 37 data points related to PREA. The form collects information on PREA complaints/investigation and tracks screening information, population, grievances, searches, and number of notifications of investigation outcomes, to name a few items. The form can track these over months to make it easier to identify trends. The definitions used by the agency in Policy MIL 1.21 Safety and Security (PREA) (Pages 1-2) are consistent with the PREA guidelines for Sexual Abuse and Sexual Harassment

Indicator (b). The agency takes collected aggregate data at the facility level and the agency level, to attempt to identify trends. CHR management interviews support an active review of all incidents to determine trends or needs. A client safety issue identified in non-PREA incidents could result in a solution that could also benefit sexual safety (i.e., Camera purchases). The facility has completed an annual report which shows aggregate data.

Indicator (c). Interviews with the Agency PREA Coordinator and Service Director supports information from the PREA data collection form were compared by the Auditor to the SSV-4 form. The Auditor was able to complete the document minus the end of the year population number. The Agency has not been requested to complete the SSV-4 form by state or federal officials.

Indicator (d). All incident reports and investigations are forwarded to the agency PREA Coordinator for the required storage.

Indicator (e). N/A- the facility does not contract for the confinement of residents.

Indicator (f). N/A- The Department of Justice has not asked Milestone for the SSV data, though the elements collected by the facility and the PREA Coordinator to support an ability to complete said report.

Compliance Determination
The Community Health Resources collects information sufficient to complete the Survey of Sexual Victimization (SSV) at Milestone. Indicator (e) does not apply as CHR does not contract for beds. Milestone has not been requested to complete the SSV report or provide other related data to the Department of Justice (indicator (f). Absent any incidents of sexual misconduct, the Auditor had to rely on agency knowledge of expectations. The agency Policy (Mil 1.21) commits the agency to comply with the standard's data collection requirement. The Compliance is based on the information provided to the Auditor and the interview with the Agency PREA Coordinator and the Service Director who oversees Milestone.

Standard 115.288: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.288 (a)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.288 (b)

- 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 ☐ No

115.288 (c)

- 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 ☐ No

115.288 (d)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and written/electronic documentation reviewed.
Policy GAP 1.16 Incident Reporting
Policy GAP 1.17 Sentinel or Adverse event reviews
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21Safety and Security PREA

Individuals interviewed/ observations made.
PREA Coordinator
Senior Vice President
Service Director

Indicator Summary determination.

Indicator (a). CHR's PREA Coordinator reportedly meets with the agency leadership regularly. The group reviews any PREA related concerns or other client safety issues and looks for trends. If a sexual abuse incident review identified a concern, this group would further assess the nature of the corresponding response at the agency level. Since this group member would also be involved in the facility level reviews, they would enable change, when needed, across all facilities. These steps provide the basis for the annual report analysis. Agency policy states, "The agency shall review data collected and aggregated pursuant to 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; and Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole."

Indicator (b). During the pre-audit period, the Auditor recognized that the agency did not have an annual report on its efforts toward a sexually safe environment. The Service Director was provided information on different websites to review other agency PREA reports.

Indicator (c). The Annual Report was not on the agency website. In discussions with the Vice President of Adult Services and the Service Director, the Auditor discussed the content of the report and the standard's expectation that it is publicly available. The report was still not available at the time of the issuing of the interim report. The Service Director confirmed that it is in final stages and that it is approved through the executive director before being published to the website. The agency has had no PREA related complaints.

Indicator (d). The agency has not had to redact information to date that would impact the security of the facility or the privacy of its clients.

Compliance Determination
Milestone and the Community Health Resources policy addresses the standard's requirements on the use of data for corrective action. Since the facility does not have a history of PREA incidents, there is limited data from which to make a critical analysis. As a result, the agency looks at these events, along with other non-PREA events, when determining safety concerns. Interviews with the PREA Coordinator, the Senior Vice President of Adult Services and the Service Director all support an agency with experience utilizing data to inform practice. Agency Policy GAP 1.71 Sentinel or Adverse Event Reviews support an agency commitment to providing for client safety through a critical review of incidents and data. There is an understanding that the annual report must be completed and published to the agency's website. Compliance is based on the data provided and reviewed during the corrective action period, the information posted to the agency website and the interviews. The interviews supported a consistent message; that data analysis for program improvement is an agency-wide practice.

Standard 115.289: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- 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 ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Overall Compliance Determination Narrative

Policies and written/electronic documentation reviewed.
Policy MIL 1.05 PREA Community Confinement Standards
Policy MIL 1.21Safety and Security PREA
CHR website
Annual PREA reports

Individuals interviewed/ observations made.
PREA Coordinator
Service Director
Tour of Milestone

Indicator Summary determination.

Indicator (a). Agency records are maintained securely in an electronic software program. The system reportedly utilizes access controls to different fields of information based on an employee job description. The facility has to comply with state and federal privacy laws including HIPPA. Agency policy MIL 1.21 (page 10) states, “The program shall ensure that data collected pursuant to sexual abuse or sexual harassment investigations are securely retained.”

Indicator (b). CHR has a website that will house individuals' access to the annual data reports on incidents of sexual abuse.

Indicator (c) The Auditor’s review of aggregate reports shows no identifiers are used that could result in the identification of any victim of sexual abuse. There were no cases of sexual misconduct complaints at the Milestone program since the last Audit

Indicator (d). The PREA Coordinator reports PREA data will be maintained for at least ten years. Agency policy MIL 1.21 (page 10) states, “The program 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.”

Compliance Determination
The Community Health Resources PREA policy MIL 1.21 addresses the requirements of this standard on page 10. All Milestone data related to PREA will be provided to the agency PREA Coordinator responsible for maintaining and securing all data. If the facility had an incident, all identifying information would be removed before any information is made public. There is no state or local law requiring longer maintenance of the records.
Compliance is based on the information provided in the annual report, which includes no identifiers. The policy indications on handling information support compliance, as did interviews with the agency’s PREA Coordinator and Service Director. The interviews support an understanding that all data is maintained for at least ten years. The annual report is posted on the agency website as required.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- 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 ☒ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ 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.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Overall Compliance Determination Narrative

Policies and written/electronic documentation reviewed.
CHR Website/ PREA

Individuals interviewed/ observations made.
TOUR of Milestone
General observation of staff and residents interactions by the Auditor

Indicator Summary determination.
Indicator (a). CHR has only one program that currently undergoes PREA Audits. The Milestone Program was last Audited in 2016.

Indicator (b). CHR Milestone site visit occurred in year one of the audit cycle.

Indicator (h. The Auditor was provided access to all areas during the tour, if he had follow up questions he was allowed to return to areas for additional viewing. The Auditor, staff, and residents practiced social distancing, with interviews occurring with more than 8 feet of space between the auditor and the person being interviewed. The interview space was in a private conference room.

Indicator (i). The Auditor was permitted to request and receive copies of relevant documents. Information was provided in advance, and more was furnished at the Auditor's request when on-site.

Indicator (m). The Auditor was able to meet in a private space with clients and staff. The auditor used the second-floor conference room on days one and two.

Indicator (n). Postings providing the Auditor's contact information were posted throughout the facility. The Auditor confirmed the postings were up for weeks prior to the site visit in interviews and through photo's provided in advance. There was no correspondence from any current or former resident, staff member or other interested parties.

Compliance Determination
The standard is compliant based on evidence that the organization Community Health Resources has provided. Though indicator (a) was not in compliance as the last audit was over three years ago the agency has no other facilities required to undergo PREA audits by a funding sources. The facility is required to complete the audit by the funding source of 2 of the 16 beds. The facility was helpful in the preparation of documents and the support of staff to get the identified individuals to the interviews in a timely manner. Video conferences were scheduled for Agency administrators who could not be onsite.

The agency also worked with the auditor during the post-audit period to complete the required corrective actions.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY 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 that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Overall Compliance Determination Narrative

Policies and written/electronic documentation reviewed.
Policy Mil 1.21 Safety and Security (PREA)
CHR website
20016 PREA Audit reports

Individuals interviewed/ observations made.
PREA Coordinator
Service Director

Summary determination
Indicator (f). The Community Health Resources has posted on its agency's website (CHRhealth.org) the PREA Audit reports of the Milestone's first PREA Audit in 2016. The Auditor confirmed with agency leadership that once finalized, this report must be posted to the site.

Compliance determination
The Community Health Resources has come into compliance during this corrective action period through publishing to the agency website the prior PREA report and the agency's leadership's understanding that it will publish this report upon finalizations to the same website.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Jack Fitzgerald 2-15-21

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.


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