PREA Facility Audit Report: Final

Name of Facility: Renaissance West
Facility Type: Community Confinement
Date Interim Report Submitted: NA
Date Final Report Submitted: 06/27/2025

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	☑
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Latera M. Davis	**Date of Signature:** 06/27/2025

AUDITOR INFORMATION	
Auditor name:	Davis, Latera
Email:	laterad@yahoo.com
Start Date of On-Site Audit:	03/13/2025
End Date of On-Site Audit:	03/14/2025

FACILITY INFORMATION	
Facility name:	Renaissance West
Facility physical address:	466 West Main Street, Waterbury, Connecticut - 06702
Facility mailing address:	

Primary Contact

Name:	Katie Seto
Email Address:	kseto@ctrenaissance.org
Telephone Number:	475-225-9089

Facility Director	
Name:	Chantel Herron
Email Address:	cherron@ctrenaissance.org
Telephone Number:	203-249-8490

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

Facility Characteristics	
Designed facility capacity:	44
Current population of facility:	38
Average daily population for the past 12 months:	27
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Men/boys
In the past 12 months, which population(s) has the facility held? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For	

definitions of “intersex” and “transgender,” please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	18+
Facility security levels/resident custody levels:	Level 1
Number of staff currently employed at the facility who may have contact with residents:	37
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	4
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

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

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

Agency-Wide PREA Coordinator Information

Name:	Katie Seto	Email Address:	kseto@ctrenaissance.org

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
0	

Number of standards met:
41

Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION	
GENERAL AUDIT INFORMATION	
On-site Audit Dates	
1. Start date of the onsite portion of the audit:	2025-03-13
2. End date of the onsite portion of the audit:	2025-03-14
Outreach	
10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	JDI, Connecticut Alliance Against Sexual Assault, Safe Haven
AUDITED FACILITY INFORMATION	
14. Designated facility capacity:	44
15. Average daily population for the past 12 months:	27
16. Number of inmate/resident/detainee housing units:	3
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
18. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	41
19. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	2
20. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	1
21. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
22. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	1
23. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
24. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	6

25. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
27. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	14
28. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
29. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all residents in the facility. The facility houses male and inmates. The facility was able to utilize data from the risk assessment to identity any targeted populations.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
30. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	35
31. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	3

32. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
33. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	The facility had a diversity in terms of age, gender, ethnicity and background of staff, volunteers and contractors. While the facility had a high turnover rate, there was a range of experience and expertise among staff. The facility employed a versatile staff force that had notable qualification and specialized skills to contribute to the overall facility operations.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

34. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	10
35. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☐ Gender ☐ Other ☐ None

36. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all residents in the facility. The facility houses all male residents. The facility was able to utilize data from the risk assessment to identity any targeted populations.
37. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	(●) Yes ( ) No
38. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all residents in the facility. The facility houses all male residents. The facility was able to utilize data from the risk assessment to identity any targeted populations.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	2
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/ resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/ residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
40. Enter the total number of interviews conducted with inmates/residents/ detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	3

41. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	1
42. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	1
43. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	1
44. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
44. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

44. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.
45. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
45. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
45. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.

46. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
46. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
46. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.
47. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
47. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

47. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.
48. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
48. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
48. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.

49. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
49. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
49. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Based on our recent audit at the facility, we have identified several critical observations regarding the targeted population interviews: The facility claimed that there were no other residents in this category available during the onsite portion of the audit and was unable to provide a list of these residents. Our corroboration strategies included reviewing documentation onsite, obtaining information from the PAQ, and having discussions with staff and other residents, but no residents meeting these criteria were identified.
50. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	As an auditor, the process of selecting residents for interviews is designed to ensure a fair and unbiased representation of the population. We use a random selection method, often through a random number generator or a similar unbiased tool, to choose residents from the list. This process helps us gather a diverse range of perspectives and ensures that no particular group is either favored or overlooked. Our goal is to obtain an accurate and comprehensive understanding of the environment and conditions from various residents' viewpoints.

Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
51. Enter the total number of RANDOM STAFF who were interviewed:	12
52. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☐ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
53. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
54. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all staff by title and shift.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	20
56. Were you able to interview the Agency Head?	◉ Yes ○ No

57. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
58. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
59. Were you able to interview the PREA Compliance Manager?	( ) Yes ( ) No (●) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

60. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☐ Agency contract administrator ☑ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☑ Medical staff ☑ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff

	☐ Other
61. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
62. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
63. Provide any additional comments regarding selecting or interviewing specialized staff.	Individuals was not working during the audit process.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

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

64. Did you have access to all areas of the facility?	◉ Yes ○ No
Was the site review an active, inquiring process that included the following:	
65. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	◉ Yes ○ No

66. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
67. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
68. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No
69. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	Site Review is noted throughout the audit.

Documentation Sampling

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

70. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No

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

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

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

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

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

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

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

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

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

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

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

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

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

Sexual Harassment Investigation Outcomes

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

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

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

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

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	1	0
Total	0	0	1	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

78. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	0
78. Explain why you were unable to review any sexual abuse investigation files:	There zero identified allegations.

79. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
80. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
81. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
82. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
83. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
84. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

85. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
86. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	1
87. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	◉ Yes ○ No ○ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
88. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
89. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
90. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
91. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	1
92. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
93. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
94. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	No text provided.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

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

Non-certified Support Staff	
96. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	(●) Yes ( ) No
96. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1
AUDITING ARRANGEMENTS AND COMPENSATION	
97. Who paid you to conduct this audit?	(●) The audited facility or its parent agency ( ) My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ( ) A third-party auditing entity (e.g., accreditation body, consulting firm) ( ) Other

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

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Documentation: · Pre-Audit Questionnaire · Policy: Prison Rape Elimination Act (PREA) · Agency Organization Chart · Waterbury West Organization Chart Interviews: · Agency PREA Coordinator

	Compliance Determination by Provisions and Corrective Actions: 115.211 (a). An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Per the PAQ: The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility has a written policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. · Policy: Prison Rape Elimination Act. The policies mandate a zero tolerance toward all forms of sexual abuse and sexual harassment (p. 1). The policies outlined the approach to prevent, detect, and response to sexual abuse and sexual harassment. The policy further defines sexual abuse and sexual harassment (pp.1-7). Additionally, the policy includes the definition of sexual abuse and sexual harassment, and sanctions for those to have participated in prohibited behaviors Corrective Actions: N/A. There are no corrective actions for this provision. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.211 (b). An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all its facilities. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency employs or designates an upper-level, agency-side PREA coordinator. It was further reported that the PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. The position of the PREA Coordinator is the "PREA Coordinator."

	· Policy: Prison Rape Elimination Act. The agency/facility has PREA policies which ensure the sexual safety of facility residents and staff. The policy includes zero-tolerance philosophy from the agency central office through the front-line staff in its facilities. The agency/facility PREA coordinator has direct access to the head of the agency and regular communication with the senior leadership team. · Agency Organization Chart: As reported on the organization chart, the agency PREA Coordinator title is: Clinical Performance & Outcomes Director and PREA Coordinator. The position reports to the Chief Operating Officer. · Waterbury West Organization Chart Interviews: PREA Coordinator: The staff interviewed reported that they have enough time to manage their PREA-related responsibilities. It was further reported that as the PREA Coordinator, I oversee the agency's PREA response and am the agency's main point of contact for PREA. My efforts include, but are not limited to taking PREA reports, monitoring and updating PREA policies and written materials, providing PREA training and guidance, managing administrative investigations, answering questions about PREA and CT Renaissance's PREA response, and generally reinforcing the agency's zero tolerance policy and client safety. PREA training is provided monthly to new hires, monitor PREA documentation in our programs, and ensure PREA compliance. Corrective Actions: N/A. There are no corrective actions for this provision. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.212	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination:

	Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) State of Connecticut Contract Findings (By Provision): 115.212 (a). As reported in the PAQ, the agency has not entered or renewed any contract for the confinement of residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency/facility does not contract with another entity for the confinement of its Residents. · The agency serves as a contracted provider for the Department of Corrections (State of Connecticut Purchase of Service Contract). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.212 (b). As reported in the PAQ, the agency policy does require the agency to monitor contracts if they have them. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.212(c). As reported in the PAQ, the agency has not entered or renewed any contract for the confinement of residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: · The facility has not had any emergency circumstances in which all reasonable attempts to find a private agency or other entity in compliance with the PREA standards have failed because the facility does not contract with other entities to house their residents. Corrective Actions:

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

115.213	**Supervision and monitoring**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Supervision and Monitoring-Staff Staffing Plan Assessment (2024/2025) Staffing Plan (2024/2025) Layout of Facility Staffing Schedule Interviews: Director or Designee PREA Coordinator Findings (By Provision): 115.213(a). For each facility, the agency shall develop and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, agencies shall take into consideration: (1) The physical layout of each facility; (2) The composition of the resident population; (3) The prevalence of substantiated and unsubstantiated

	incidents of sexual abuse; and (4) Any other relevant factors. Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: · As reported in the PAQ, the agency requires each facility it operates to develop, document and make its best efforts to comply on a regular basis with a staffing plan. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents: 29. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents on which the staffing plan was predicated: 44. · Staffing Plan and Staffing Plan Assessment (1/2025): provides documentation of the agency staffing plan and annual assessment that was completed on 1/ 13.2025) · Staffing Plan and Staffing Plan Assessment (2024 and 2025): provides documentation of the agency staffing plan and annual assessment that was completed. · The staffing plan minimum requirements are determined by the funder, CT Department of Corrections. The number of residents in the program determines the minimum number of staff that should always remain on the floor. The minimum staff requirements can never be deviated from so the staff will always ensure that the minimum staffing is present on the floor. The facility has video monitoring in blind spots throughout the facility and continues to add cameras as money becomes available. Staff complete hourly headcounts/rounds as an additional means of supervision. · The Staffing Matrices are established by the funding source however the funding source is open to suggestions based on the agency's on-going assessments of their needs. The staffing matrix is submitted every year. If the agency/facility has changes to recommend, the funding agency does consider the justifications for the requests. · The facility provided a comprehensive layout of the entire premises and the location of residents. Site Review: Observations Related to Staffing, Visibility, and Monitoring: During the site review, the auditor observed that staff were present and actively engaged on all housing unit levels where residents were located. Staff were consistently conducting security rounds, and various groups and activities were being facilitated throughout the day. Each housing unit had a designated staff office located directly within the unit.

	These offices were secured and locked whenever staff were not present. Additionally, areas that are off-limits to residents, such as storage rooms and maintenance closets, were consistently observed to be locked, maintaining appropriate boundaries and safety protocols. The facility was equipped with surveillance cameras strategically placed throughout both the interior and exterior areas. Camera feeds were actively monitored by staff stationed in the Central Operations Desk (COD) throughout the day. Importantly, the placement of these cameras does not infringe on resident privacy, as cameras are not positioned to view into bathrooms or sleeping areas. Through informal conversations with both staff and residents, the auditor received consistent confirmation that staff conduct regular rounds and maintain a visible presence throughout the facility on a daily basis. Staff and residents alike verified that staff do not have direct visual access into resident rooms or restrooms, aligning with PREA standards on privacy and supervision. Interviews PREA Coordinator: The staff interviewed reported that Staffing plans are assessed for resident sexual safety at least annually and reviewed by the Director of Work Release, the Facility Director and the PREA Coordinator. Each plan considers and specifies the physical layout of the facility, the resident population, prevalence of incidents and other factors that impact client safety and monitoring. Findings from any incident reviews are incorporated into the plan with respect to addressing factors that may contribute to PREA incidents including accounting for staff's ability to appropriately monitor residents throughout the facility. The staffing plan is kept in a binder on site. In addition, by contract, our Work Release facility must ensure certain staffing levels, so there are no deviations of the staffing plan reported. Our location is adequately monitored by video surveillance which has the ability to play back videos. At least once a year, assessments of video monitoring needs are conducted including analyzing the number of cameras, the placement, and monitoring/dependability of systems. In addition to the annual update of the facility staffing plan, any changes that may be needed throughout the year are overseen by the PREA Coordinator, in consultation with the Director of Work Release and Facility Director. Director – The interviewed staff reported that the facility has a documented staffing plan. The plan includes staffing numbers as well as video monitoring. We look at all areas to ensure there are no blind spot, review the logs ins, and the camera system can be always reviewed, as access is available via the Directors phone. Video monitoring does not replace staff, but it is monitored to make sure clients are where they are supposed to be. When monitoring staffing, we look at clients/staff per shift, the layout of the building and the location of the staff in the building. We want to have staff on every floor. We have a monthly schedule to monitor and check for compliance. Corrective Actions:

	N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.213(b). In circumstances where the staffing plan is not complied with, the facility documents and justifies all deviations from the plan. Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: · As reported in the PAQ, there were no deviations to the staffing plan. · The facility staffing plan is based on the contract with CT DOC. In circumstances where the staffing plan is not complied with, the facility document and notified CT DOC of deviations. · Staffing Plan and Staffing Plan Assessment (2024 and 2025): provides documentation of the agency staffing plan and annual assessment that was completed. Interviews Director or Designee – The interviewed staff reported that the facility documents all instances of noncompliance with the staffing plan. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.213(c). Whenever necessary, but no less frequently than once each year, the facility shall assess, determine, and document whether adjustments are needed to: (1) The staffing plan established pursuant to paragraph (a) of this section; (2) Prevailing staffing patterns; (3) The facility's deployment of video monitoring systems and other monitoring technologies; and (4) The resources the facility has available to commit to ensure adequate staffing levels. Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: · As reported in the PAQ, at least once every year the facility, reviews the staffing plan to see whether adjustments are needed in (1) the staffing plan, (2)

	prevailing staffing patterns, (3) the deployment of video monitoring systems and other monitoring technologies, or (4) the allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan. · Policy: Supervision and Monitoring-Staffing outlines the agency procedures for completing the staffing plans (p. 1). · Staffing Plan and Staffing Plan Assessment (2024 and 2025): provides documentation of the agency staffing plan and annual assessment that was completed. · The staffing plan is objective with the number and placement of staff and some video technology that is necessary to ensure the sexual safety of the resident population given the facility layout and characteristics, classifications of residents, and security needs and programming. · The agency/facility makes its best efforts to comply on a regular basis with the staffing plan and the facility document deviations from the staffing plan. The agency PREA coordinator is a part of the annual review. Interviews PREA Coordinator – The interviewed staff reported that all staffing plan updates are made in consultation with the PREA Coordinator and reviewed at least once per year. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.215	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Searches Facility and Person CT Renaissance Training Cross-Gender and Transgender Pat Searches Copy of Pat Search Steps PREA Training Curriculum PREA Training Staff Sign Off (30) Resident Handbook Interviews: Resident Interview Questionnaire (10) Random Sample of Staff (12) Compliance Determination by Provisions and Corrective Actions: 115.215 (a). The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. In the past 12 months, the number of cross-gender strip or cross-gender visual body cavity searches of residents: 0 · In the past 12 months, the number of cross-gender strip or cross-gender visual body cavity searches of residents that did not involve exigent circumstances or were performed by non-medical staff: 0 · The facility does not conduct strip searches or body cavity searches at all. Staff are prohibited from conducting any form of search that involves “touching” by either gender staff. Residents are afforded the utmost privacy in restroom/shower areas where the restroom has stalls and doors, and the showers have stalls and curtains and the doors to the restroom/shower areas may be closed as well. Staff are respectful of residents’ living areas and their privacy.

	· There have been no strip search or body cavity searches, and these are prohibited, nor have there been any searches involving “touch.” Residents have privacy while changing clothing because of doors on their rooms. Policy requires Residents and staff to be subject to hands-off searches that will be conducted in a manner that avoids force, embarrassment or indignity to the person being searched. It also requires that pat downs, body cavity and strip searches are prohibited regardless of the gender of the staff or Resident, even in exigent circumstances. · Policy: Searches Facility and Person states that: o As per the Department of Correction and CSSD contractual agreements, all clients returning to the building from Community passes are to be Pat-Down Searched. This does not include a client returning from a supervised smoke break or recreation unless a client was unobserved or had contact with the public. Cross gender pat-down searches will be conducted only in exigent circumstances. Exigent circumstances means any set of temporary and unforeseen circumstances that require immediate action in order to combat a threat to the security or institutional order of a facility. Pat down searches will be conducted as follows: 1. All Clients will enter the building through a central door. 2. Designated staff will process and search one client at a time. 3. Clients will be signed in by staff. 4. Client will remove hat, coat, shoes, and any items on person (including bags, backpacks, etc.) Staff will search those items. 5. Client will be asked to move to a designated pat down area (this will be conducted in an area visible by video camera) 6. Pat down search will be conducted by same gender staff 7. When, in exigent circumstances, a cross-gender pat down search occurs, documentation shall be completed and submitted to DOC and the Clinical Performance and Outcomes Department. 8. All applicable staff will be trained in Pat down search procedures upon hire and will be observed by Program Director or designee for competency in the pat-down procedure. This observation will be documented in the staff supervision file. 9. All applicable staff will participate in, at a minimum, an annual retraining in Pat down search procedures or as contractual agreement dictates. 10. All staff is prohibited from searching a transgender or intersex client for the purpose of determining genital status (p. 3). Audit Site Review: Observations Related to Search Procedures and Cross-Gender Practices: The auditor directly observed the designated area where pat-down searches are conducted upon residents’ entry into the facility. The facility does not conduct strip searches; however, pat-down searches are standard practice during intake. During the observed process, staff instructed residents to remove their shoes and empty their pockets prior to the search. The pat-down search was conducted by male staff and occurred within the line of sight of facility surveillance cameras, consistent with agency policy and PREA standards. All searches are documented in a designated logbook. The auditor interviewed two residents regarding the search procedures. Both residents confirmed that female staff rarely conduct pat-down searches. In

	instances where cross-gender searches do occur, the facility documents these occurrences, maintaining transparency and accountability in alignment with PREA requirements concerning cross-gender searches. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.215 (b). As of August 20, 2015, or August 20, 2017, for a facility whose rated capacity does not exceed 50 residents, the facility shall not permit cross-gender pat-down searches of female residents, absent exigent circumstances. Facilities shall not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances (facilities have until August 20, 2015, to comply; or August 20, 2017, if their rated capacity does not exceed 50 residents). It further states that the facility does not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision. N/A as the site is an all-male facility. · Resident Handbook: The resident handbook provides the client of an overview of when and how pat searches are conducted. Interviews Random Sample of Staff – There were no female residents at the program. Resident Interview Questionnaire (Female Residents)- There were no female residents at the program. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.215 (c). The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches and shall document all cross-gender pat-down searches of female residents.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · N/A-the facility does not conduct cross-gender strip searches or visual cavity searches. · N/A-there are no female residents at the facility. · Policy: Searches and Facility Person states that “Staff shall conduct and document a search of a client's person only when there is reason to believe the client is in possession of contraband and or stolen property” (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.215 (d). The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. · Policies and procedures require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. · Policy: Searches of Facility and Person states that “All Agency staff is prohibited from viewing residents while dressing, showering or performing bodily functions” (p. 1).

	Site Review: Observations Related to Cross-Gender Viewing, Announcements, Privacy, and Confidentiality: During the site review, the auditor assessed the facility’s adherence to PREA standards regarding cross-gender viewing and resident privacy. The auditor toured housing units, intake areas, bathrooms, showers, and common areas. It was observed that staff are not in direct line of sight of residents during activities where they may be undressed, such as showering, toileting, or changing clothes. Residents are able to use bathroom facilities with doors closed, ensuring privacy without staff interruption. The auditor also observed the implementation of cross-gender announcements, a critical operational function. Staff were consistently heard announcing their presence before entering housing or living areas of the opposite gender. The commonly used verbal alerts were "female in the unit" or simply "female," ensuring residents were aware and could maintain their privacy. In addition, the auditor reviewed the placement and orientation of surveillance cameras as monitored from the main control room. The electronic surveillance system is positioned to avoid capturing images of residents in a state of undress, including while using showers or toilets. Surveillance monitoring occurs in the Central Operations Desk (COD) and is also accessible to leadership through secure devices. While staff of the opposite gender do have access to the video monitoring system, the system does not include views of resident bedrooms or bathrooms, preserving resident dignity and complying with PREA privacy standards. The auditor also evaluated the handling of sensitive resident information. Hard copy documentation, such as PREA screening forms, is securely stored in residents’ individual files within locked filing cabinets in secured rooms. No confidential information was found to be accessible to unauthorized staff or residents. Additionally, the facility has implemented an electronic system for managing PREA screening assessments, enhancing the confidentiality and security of sensitive data. Informal conversations with residents indicated a general sense of safety and awareness of staff practices. Two residents interviewed stated that staff consistently make cross-gender announcements and confirmed that they are not seen while changing clothes, showering, or using the toilet. Staff interviews further confirmed that personnel are trained to make such announcements and that all staff have appropriate access to the camera system for supplemental monitoring, while maintaining compliance with privacy protocols. Interviews Resident Interview Questionnaire – Ten residents were interviewed, and nine residents confirmed that staff announce their presence when entering the housing area, especially when a female officer is entering the unit. Staff will knock as well and wait for residents to response before opening the door. One resident reported

	that staff do not announce themselves when entering the housing area and has entered few times and saw them getting dressed. Nine confirmed that privacy measures prevent others from seeing them while using the toilet, showering, or changing clothes in their individual bathrooms. One resident mentioned that staff sometimes enter without knocking or announcing themselves, leading to occasional interruptions. Random Sample of Staff – Twelve staff were interviewed during the audit period. Ten out of the twelve staff interviewed stated they announce themselves when entering the housing area of residents as well as knock to give residents time to get dressed if needed. One staff member stated that he sometimes will not announce if it is late at night to avoid waking resident will just lightly knock. Two staff stated because of their job duties they do not conduct rounds or enter residents' rooms therefore no reason to announce. The staff confirmed that residents in custody can dress, shower, and use the toilet without being observed by staff or members of the opposite gender, as each has their own bathroom in their rooms. Correction Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.215 (e). The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. There were zero reported searches that occurred in the last 12 months. · Policy: Searches of Facility and Person states that "All staff is prohibited from searching a transgender or intersex client for the purpose of determining genital status." (p. 3). Interviews Random Sample of Staff – Twelve staff were interviewed during the audit period. Ten out of the twelve staff interviewed stated they announce themselves when entering

	the housing area of residents as well as knock to give residents time to get dressed if needed. One staff member stated that he sometimes will not announce if it is late at night to avoid waking resident will just lightly knock. Two staff stated because of their job duties they do not conduct rounds or enter residents' rooms therefore no reason to announce. The staff confirmed that residents in custody can dress, shower, and use the toilet without being observed by staff or members of the opposite gender, as each has their own bathroom in their rooms. Transgender/Intersex Residents – There were no transgender or intersex residents onsite during the onsite portion of the audit. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.215 (f). The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 100% of staff who have received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional manner with security needs. · The agency/facility provided the auditor copies of staff training power points that include slides on conducting cross-gender pat down searches, and searches of transgender and intersex Residents in a respectful manner. · Training Curriculum: The agency uses the training curriculum created by the Moss Group and available on the PREA Resource Center. · Cross-Gender Pat-Down Search Documentation Report provides a mechanism to document said searches. · CT Renaissance Training Cross-Gender and Transgender Pat Searches provides the agency steps for conducting said searches. · PREA Pat Searches Training Sign Off (30) As part of the compliance audit with the Prison Rape Elimination Act (PREA) standards, I have reviewed the facility's training curriculum and delivery methods related to pat searches. The training program appropriately addresses the requirements outlined in PREA Standard §115.215, ensuring that all staff responsible for conducting pat-down searches

	receive specific instruction on how to perform searches in a professional, respectful, and least intrusive manner possible, consistent with security needs. · The training includes content on conducting pat searches of transgender and intersex individuals in a manner that upholds dignity and reduces the risk of trauma or humiliation. It also emphasizes the importance of cross-gender search protocols and provides clear guidance aligned with agency policy. · The reviewed training materials—consisting of lesson plans, presentations, and staff sign-in sheets—demonstrate that staff are trained both at initial orientation and during annual refreshers. Interviews with staff further confirm their understanding of PREA search procedures and their ability to apply them in practice. Interviews Random Sample of Staff – All of the interviewed staff reported that they that the facility prohibits staff from searching or physically examining a transgender or intersex detainee for the purpose of determining that detainee's genital status. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard

115.216	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act (PREA)

	Policy: Admission and Orientation Language Line/Language Line Brochure Staff PREA Training Sign Off (9) Resident Handbook Written Material (Brochure-English/Spanish) Corrective Action: Memo: Interpreter Services Interviews: Agency Head Residents (with disabilities or who are limited English proficient) (1) Random Sample of Staff (12) Findings (By Provision): 115.216 (a). The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans with Disabilities Act, 28 CFR 35.164. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

	· Policy: The Prison Rape Elimination Act (PREA) Policy states that “The agency prohibits the use of residents as interpreters in matters regarding allegation of sexual abuse/harassment during an internal investigation unless the delay could compromise the resident’s safety. The agency has identified a staff member for Spanish speaking individuals who would be able to provide interpreter assistance as needed. The Agency will provide materials related to the zero-tolerance policy in the language of current limited English proficient residents. The agency will create a system for staff to access alternative language lines for additional interpretive services. Information regarding access to the Language Line is available in the PREA Binder available through the program Director or in the COD office. In the case of a LEP client (limited English proficiency) or disabled person unable to read and/or understand the written PREA policy, a staff member will read the PREA policy and elicit responses to confirm that the person understands the policy. Someone who is severely disabled may meet our exclusionary criteria for admission. (p. 1). · Policy: Admission and Orientation Work Release Programs states that “The program shall provide orientation and information in a manner of which can be understood by the person served. Information shall be in formats that are accessible to those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as those who have limited reading skills” (p. 2). · Contracts for Interpreter Services: The facility does not have a contract for interpreter services however has access to said services through LEP Language Line. · Resident Handbook: The resident handbook provides information to residents that the they can seek assistance from staff if there is a need for language or literacy assistance. · Written Material (Brochure-English/Spanish) · Staff Training: Staff receive training on collaborating with individuals with disabilities during the PREA training. The auditor reviewed documentation on (12) new hire training records to verify compliance. Site Review: Observations Related to Language Access and Interpretation Services: During the site review, the auditor assessed the facility’s procedures for providing language access and securing interpretation services. The auditor independently contacted the contracted telephonic interpretation service (Language Line) and confirmed that it was functional and accessible. Services were available immediately upon request, and no personal identification was required from residents to utilize the service—only an agency-specific access code. Although the use of the Language Line must be coordinated through the Director due to associated costs, the facility mitigates this by ensuring residents have immediate access to multiple bilingual staff members, particularly for Spanish—the

	most commonly spoken non-English language among the resident population. Additionally, residents have access to personal cell phones, which may facilitate communication needs in a variety of languages, although official interpretation for PREA-related matters must still follow agency-approved channels. Informal conversations with staff revealed that the agency employs a bilingual case manager who is based at another program within the facility complex and is accessible as needed. Several staff members onsite also speak Spanish and are available to assist with communication. Case managers interviewed were able to clearly articulate the procedure for requesting interpreter services and expressed confidence in accessing support if a resident with limited English proficiency required assistance. These findings indicate that the facility has effective systems in place for ensuring meaningful access to communication for limited English proficient residents, consistent with PREA standards. Interviews Agency Head – The interviewed agency head reported that the agency has a partnership with interpreter services. The most common secondary language is Spanish and typically have Spanish speaking staff at all sites. For disabilities we would partner with one of our community providers. Residents (with disabilities or who are limited English proficient) – There was one resident identified with a disability. The interviewed residents reported that the facility provided information about sexual abuse and sexual harassment in a manner in which they could understand. The resident stated that they were given the opportunity to speak one on one with case manager and review handbook during the intake process upon their arrival at the facility. The resident further stated that a staff member would be willing to assist them in understanding information about sexual abuse or harassment if they had questions or did not understand. They also expressed that they felt comfortable asking a staff member for help if they needed to make a report. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.216 (b). The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse or sexual harassment. · Policy: The Prison Rape Elimination Act (PREA) Policy states that "The agency prohibits the use of residents as interpreters in matters regarding allegation of sexual abuse/harassment during an internal investigation unless the delay could compromise the resident's safety. The agency has identified a staff member for Spanish speaking individuals who would be able to provide interpreter assistance as needed. The Agency will provide materials related to the zero-tolerance policy in the language of current limited English proficient residents. The agency will create a system for staff to access alternative language lines for additional interpretive services. Information regarding access to the Language Line is available in the PREA Binder available through the program Director or in the COD office. In the case of a LEP client (limited English proficiency) or disabled person unable to read and/or understand the written PREA policy, a staff member will read the PREA policy and elicit responses to confirm that the person understands the policy. Someone who is severely disabled may meet our exclusionary criteria for admission. (p. 1). · Policy: Admission and Orientation Work Release Programs states that "The program shall provide orientation and information in a manner of which can be understood by the person served. Information shall be in formats that are accessible to those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as those who have limited reading skills" (p. 2). · Written Material (Brochure-English/Spanish) · PREA Training: The PREA training material as discussed in standard 115.231 addresses working with vulnerable populations. · Staff Training: PREA Training documented in Standard 115.231. The training curriculum addresses collaborating with residents who are disabled and/or limited English Proficient. · Site Review (same as a). Interviews Residents (with disabilities or who are limited English proficient) – There was one resident identified with a disability. The interviewed residents reported that the facility provided information about sexual abuse and sexual harassment in a manner in which they could understand. The resident stated that they were given the opportunity to speak one on one with case manager and review handbook during the intake process upon their arrival at the facility. The resident further

	stated that a staff member would be willing to assist them in understanding information about sexual abuse or harassment if they had questions or did not understand. They also expressed that they felt comfortable asking a staff member for help if they needed to make a report. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.216 (C). The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency policies prohibit other use of resident interpreters, resident readers, or other type of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties, or the investigation of the residents' allegations. Furthermore, the agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. · In the past 12 months, the number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations: 0. · Policy: The Prison Rape Elimination Act (PREA) Policy states that "The agency prohibits the use of residents as interpreters in matters regarding allegation of sexual abuse/harassment during an internal investigation, unless the delay could compromise the resident's safety." (p. 1). · There were no identified or documented circumstances when resident interpreters, readers, and other resident assistants were used. Interviews Random Sample of Staff – All of the interviewed staff reported that they have never seen the agency allow resident to serve as interpreters for each other. Eight staff

	stated they would seek assistance from another staff member for interpretation, while two indicated they would contact a supervisor for next steps and two stated they would ask another staff or call the language assistance line. Residents (with disabilities or who are limited English proficient) – There was one resident identified with a disability. The interviewed residents reported that the facility provided information about sexual abuse and sexual harassment in a manner in which they could understand. The resident stated that they were given the opportunity to speak one on one with case manager and review handbook during the intake process upon their arrival at the facility. The resident further stated that a staff member would be willing to assist them in understanding information about sexual abuse or harassment if they had questions or did not understand. They also expressed that they felt comfortable asking a staff member for help if they needed to make a report. Corrective Actions: N/A. There are no corrective actions for this provision Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Following analysis, it has been determined that the facility is compliant with the standard.

115.217	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act Policy: Employment (2024) Personnel File (9 new hire):

	· New Hire Orientation Checklist · Reference Check Form · Internal Career Application · PREA-Employment Questionnaire · Employment Application · Background Check · Staff PREA Understanding 5-year background checks (9) Workplace code of conduct Interviews: Administrative (Human Resources) Staff Findings (By Provision): 115.217 (a). The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency policy does not prohibit hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who: o Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution. o Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or o Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2).

	o Employee Records: Document Employee Records provide an overview of the background check process and employee file. o Employee Records: Document Employee Records provide an overview of the background check process and employee file. o Policy: Employment provides guidance on the hiring process for employees. o Personnel Files (9). Personnel files were reviewed and verified that criminal record background checks were conducted and questions regarding pat conduct were asked and answered. Corrective Actions: N/A. There are no corrective actions. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.217 (b). As reported in the PAQ, the agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Policy: Employment states that “Connecticut Renaissance will consider any prior reported incidents of sexual harassment in determining whether to hire, appoint, or promote an individual who may have contact with a person in the custody of the Judicial Branch or the Department of Correction” (p. 3). Interviews Administrative (Human Resources)- The staff interviewed reported that the agency conducts prior institutional reference checks. We also assess for promotions. Corrective Actions: N/A. There are no corrective actions. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.217 (c). Before hiring new employees, who may have contact with residents, the agency shall: (1) Perform a criminal background records check; and (2) Consistent with Federal, State, and local law, make its best efforts to contact all

	prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. · In the past 12 months, the number of persons hired who may have contact with residents who have had criminal background record checks: not answered. · Policy: Employment provides guidance on the hiring process for employees. · Personnel Files (9). Personnel files were reviewed and verified that criminal record background checks were conducted and questions regarding pat conduct were asked and answered. · Prior Institutional Reference Check: there were three identified staff who required a prior institutional reference check. Interviews Administration (Human Resources Staff): The staff interviewed reported that the agency conducts background checks on all employees. The agency does not have contractors but would conduct background checks on them if there were contractors. The agency conducts criminal background checks at the state and federal level, in addition to conducting motor vehicle checks. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.217 (d). The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ, the agency policy does not require that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. In the past 12 months, the number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 0. · There are no contracted staff to review background checks. Interviews Administration (Human Resources Staff): The staff interviewed reported that the agency conducts background checks on all employees. The agency does not have contractors but would conduct background checks on them if there were contractors. The agency conducts criminal background checks at the state and federal level, in addition to conducting motor vehicle checks. Corrective actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.217 (e). The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency policy requires that criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents, or who may have contact with residents, or that a system is in place for otherwise capturing such information for current employees. · Policy: The Employee policy states that “Criminal Record Checks shall be completed prior to hire and every 5 years thereafter for all potential employees, volunteers, interns and contractors”. (p. 4). · 5- year background check (9). As part of the compliance audit with the Prison Rape Elimination Act (PREA) standards, I have reviewed the facility’s training curriculum and delivery methods related to pat searches. The training program appropriately addresses the requirements outlined in PREA Standard §115.15, ensuring that all staff responsible for conducting pat-down searches receive specific instruction on how to perform searches in a professional, respectful, and least

	intrusive manner possible, consistent with security needs. · The training includes content on conducting pat searches of transgender and intersex individuals in a manner that upholds dignity and reduces the risk of trauma or humiliation. It also emphasizes the importance of cross-gender search protocols and provides clear guidance aligned with agency policy. · The reviewed training materials—consisting of lesson plans, presentations, and staff sign-in sheets—demonstrate that staff are trained both at initial orientation and during annual refreshers. Interviews with staff further confirm their understanding of PREA search procedures and their ability to apply them in practice. Interviews Administrative (Human Resources) Staff – Criminal background and motor vehicle checks are completed by Prospect Check. The agency recently changed to a new vendor as the vendor also does drug screens. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.217 (f). The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Pre-employment Questionnaire (9) · The Pre-Employment Questionnaire utilized by the facility effectively captures the required disclosures regarding past misconduct, including prior sexual abuse in confinement settings, sexual activity facilitated by force or coercion, and substantiated incidents of sexual harassment. The questionnaire also contains clear language advising applicants that material omissions or provision of false information may result in termination. · Documentation shows that all candidates, including employees, contractors, and volunteers, are required to complete the questionnaire prior to hire or assignment. Sample personnel files reviewed confirmed consistent implementation of this practice. The facility also requires written acknowledgment of the continuing

duty to disclose any such misconduct following employment.

· Four (4) staff members who were promoted background checks were conducted as a result of a promotion along with the pre-employment questionnaire.

Interviews

Administrative (Human Resources) Staff – The interviewed staff reported that the agency asks about previous misconduct for all new hires and promotions. This is done on a pre-employment questionnaire.

Corrective Actions:

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

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

115.217 (g). Material omissions regarding such misconduct, or the provision of materially false information, are grounds for termination.

Compliance Determinations:

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

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

· Policy Employment states that “Omissions on the part of the employee, volunteer, intern or contractor or the provision of materially false information, shall be grounds for termination (p. 2).

Corrective Actions:

N/A. There are no corrective actions.

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

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

Compliance Determination:

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

	Interviews Administrative (Human Resources) Staff – The interviewed staff stated that the agency does disclose sexual abuse or sexual harassment information to other institutional employers about former employees, unless prohibited by law. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.218	**Upgrades to facilities and technology**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) IMC LLC. Interviews: Agency Head Director Findings (By Provision): 115.218 (a). When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency/facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later. Interviews Agency Head – The interviewed agency head reported that when designing or acquiring a new facility, the agency shall consider how such technology may enhance the agencies' ability to protect residents from sexual abuse. The agency typically looks at lighting, video surveillance and hidden corners. We review the layout and assess for blind spots. An example would be when we added a bathroom clear curtain on the bottom and top were included for the shower area. Director or Designee – The interviewed staff reported that there has been no substantial expansions or modifications to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later. However, if needed the PREA standards would be taken into consideration. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.218 (b). When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit. · The facility provided documentation of the upgrades made to the video monitoring system (IMC, LLC). Interviews: Agency Head – The interviewed agency head reported that when installing new

	technology or a video monitoring system, the agency should consider how it may enhance the agencies' ability to protect residents from sexual abuse. The IT director regularly updates the system and will check for blind spots. We look to see how we can upgrade and verify clarity on the camera footage. Director or Designee – The interviewed staff reported that when installing new cameras or video monitoring technology the agency shall consider whether the enhancements could better protect residents from sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.221	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reviewing and Responding to Allegations of Sexual Abuse (Reviewed: 2022) Policy: Data Collection and Review of Sexual Abuse and/or Sexual Harassment Incidents (Reviewed: 2025) Policy: Medical and Mental Health Care for Victims of Sexual Abuse (Reviewed 2025) MOU: Safe Haven of Greater Waterbury (2016/2020) Safe Haven Info Sheet Email Correspondence with Hospital

	Email Correspondence with State Police Email Correspondence with Safe Haven of Greater Waterbury Connecticut Alliance to End Sexual Violence Interviews: Random Sample of Staff (12) Findings (By Provision): 115.221 (a). To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency/facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The agency/facility is not responsible for conducting criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Department of Corrections, Waterbury Police Department, or State Police is responsible for conducting criminal investigations. When conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that: law enforcement will be immediately called to respond to allegations of sexual abuse (p. 1). Additionally, the policy provides a uniform evidence protocol for responding to allegations of sexual abuse and sexual harassment. · Policy: Data Collection and Review of Sexual Abuse and/or Sexual Harassment Incidents provides an overview of the review of all allegations and the expectation to follow the uniform evidence protocol. · Policy: Medical and Mental Health Care for Victims of Sexual Abuse provides guidance on the medical and mental health component when responding to allegations of sexual abuse. · Correspondence with Connecticut State Police: correspondence with Connecticut State Police confirmed that they would conduct the sexual abuse or criminal related investigations. Interviews Random Sample of Staff – Twelve staff interviewed could demonstrate awareness of

	the agency’s protocols but required probing to describe the steps for preserving usable physical evidence. While they could identify key actions such as separating the resident, notifying a supervisor, and completing necessary reports, they needed prompting to include critical steps such as securing the area, wearing gloves if touch anything, preventing the resident from showering, brushing teeth or using the bathroom. When asked about who conducts the investigations two staff members stated that the program manager would conduct sexual abuse investigations, while nine stated that PREA Coordinator would manage sexual abuse investigations, and one indicated that police would conduct sexual abuse investigations. Corrective Actions: Significant probing was needed in order to get the staff to explain how evidence would be managed. Staff had a variety of responses and did not seem to be sure of what to do aside from separating individuals and notifying a supervisor. It is recommended that the facility conduct additional training with staff on the evidence protocol process. Ø Additional training was conducted. No further action is needed. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.221 (b). NA-there are no youth housed at the placement. 115.221 (c). The agency shall offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility offers all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. o The number of forensic medical exams conducted during the past 12 months: 0 o The number of exams performed by SANEs/SAFEs during the past 12 months: 0

o The number of exams performed by a qualified medical practitioner during the past 12 months: 0

· Policy: Medical and Mental Health Care for Victims of Sexual Abuse states that "Connecticut Renaissance shall offer all victims of sexual abuse access to forensic medical examinations without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If the area hospitals do not have available SAFE or SANEs then the examination can be performed by other qualified medical practitioners" (p. 1).

· MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services.

· Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education).

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

Corrective Actions:

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

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

115.221 (d). The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

Compliance Determination:

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

· As reported in the PAQ, the facility attempts to make available to the victim a victim advocate from a rape crisis center, either in person or by other mean. If and when a rape crisis center is not available to provide victim advocate services, the

	facility provides a qualified staff member from a community-based organization or a qualified agency staff member. · Policy: Medical and Mental Health Care for Victims of Sexual Abuse states that "Victims shall be referred to a victim advocate at a rape crisis center. • The agency shall obtain and maintain Memorandum of Understanding with local crisis centers and the hospitals to ensure a portal for services. Documentation of the MOU will be maintained by the PREA Coordinator. • As requested by the victim, the victim advocate, Connecticut Renaissance staff and/or other requested support may accompany the victim through the forensic medical examination process and investigatory interviews and shall provide crisis intervention, information, and referrals. • A referral for treatment services shall be provided to the victim. • The Agency does not provide specialized treatment services for victims of sexual assault; victims will be referred to outside source for medical and mental health services (p. 1). · MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services. · Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education). · The auditor reviewed the Connecticut Alliance to End Sexual Violence (Support, Advocate, Prevent) website on April 3, 2025. This is a statewide agency that operates has nine (9) alliances. The Alliance's nine member centers have provided free and confidential services to children, adolescents, and adult victims of sexual violence throughout Connecticut. Survivors can access services 24/7/365 via phone or at their local center. Each center offers counseling; support groups; accompaniments in hospital, police, and court settings; case management and support while navigating complex systems post-disclosure; and a myriad of other trauma-informed services that support healing, connection, and justice. These services are available to all survivors in Connecticut – regardless of age, sex, immigration status, race, ethnicity, nationality, sexual orientation, gender identity or expression, or religious or spiritual beliefs. There is a 24-Hour, Toll-Free Hotlines: 1-888-999-5545 (English) and 1-888-568-8332 (Espanol). On April 3, 2025, at 10:18 a.m., the auditor called Connecticut Alliance to End Sexual Violence (1-888-999-5545) to test the process. A male staff member answered and explained that if no one picks up the main office number, the call rolls over to the next available center. If it's outside their region, they forward the call based on the Connecticut Zip code. Calls are private and confidential, and each of the nine centers has a local hotline number posted. On April 3, 2025, at 10:43am, the auditor contacted the Connecticut Alliance to End Sexual Violence Spanish hotline (1-888-568-8332) to test the process. A male staff member answered the call and explained that if the caller were female, he would inform his supervisor. The call would then be forwarded to the appropriate center in

	the relevant region. The review of the Zero Tolerance for Detainee Sexual Abuse and Sexual Harassment Section title “Victim Support Services” has the following information: The Connecticut State Police has partnered with the Connecticut Alliance to End Sexual Violence to provide survivors of sexual abuse with emotional support services. To access these services, contact 888-999-5545 or send a letter to: Connecticut Alliance to End Sexual Violence at 96 Pitkin St., East Hartford, CT 06108. Interviews PREA Coordinator – The interviewed staff reported that the agency shall attempt to make a victim advocate available from a rape crisis center. The facility has a Coordinated Response Plan that specifically includes the directive to offer contact to victim advocacy services. Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.221 (e). As reported in the PAQ, if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Policy: Medical and Mental Health Care for Victims of Sexual Abuse states that “Victims shall be referred to a victim advocate at a rape crisis center. • The agency shall obtain and maintain Memorandum of Understanding with local crisis centers and the hospitals to ensure a portal for services. Documentation of the MOU will be maintained by the PREA Coordinator. • As requested by the victim, the victim advocate, Connecticut Renaissance staff and/or other requested support may accompany the victim through the forensic medical examination process and investigatory interviews and shall provide crisis intervention, information, and referrals. • A referral for treatment services shall be provided to the victim. • The Agency does not provide specialized treatment services for victims of sexual assault; victims will be referred to outside source for medical and mental health services (p. 1).

	· MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services. · Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education). Interviews PREA Coordinator – The interviewed staff reported that victims of sexual abuse shall receive timely access to emergency medical treatment and crisis intervention services. Upon receiving a report, CT Renaissance will promptly connect the victim to emotional support services, appropriate treatment planning, recommended services and referrals for continued care. CT Renaissance offers all victims access to forensic medical examinations without financial cost where evidentiary or medically appropriate which are performed by SAFE (Sexual Assault Forensic Examiners) where possible or other qualified medical practitioners. Victims will be referred to a victim advocate at a rape crisis center. As requested by the victim, the victim advocate, CT Renaissance staff or other requested support may accompany the victim through the forensic exam process, investigatory interviews, crisis intervention, information, and referral process. The agency does not provide specialized treatment for sexual assault, but victims will be referred outside for medical and mental health services. Residents who Reported Sexual Abuse – There were no residents on site who reported sexual abuse during the onsite portion of the audit. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.221 (f). As reported in the PAQ, iff the agency is not responsible for investigating allegations of sexual abuse and relies on another agency to conduct these investigations, the agency has requested that the responsible agency follow the requirements of paragraphs §115.221 (a) through (e) of the standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Outside law enforcement agreement-Email Correspondence with Waterbury PD confirms the agency agreement to conduct sexual abuse investigations. · The auditor corresponded with the State Troopers who further reported that they conduct investigations at the community confinement sites across the state.

	Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.221 (g). Auditor is not required to audit this provision. 115.221 (h): For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.222	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reviewing and Responding to Allegations of Sexual Abuse (Reviewed 2022) Interviews: Agency Head Investigative Staff Findings (By Provision): 115.222 (a). The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

Compliance Determinations:

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

· As reported in the PAQ, the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse or staff sexual misconduct). In the past 12 months, the number of allegations of sexual abuse and sexual harassment that were received: 1. In the past 12 months, the number of allegations resulting in an administrative investigation: 1. In the past 12 months, the number of allegations referred for criminal investigation: 0.

· Policy: Reviewing and Responding to Allegations of Sexual Abuse states that "Investigations into allegations of sexual abuse and sexual harassment shall be done so promptly, thoroughly, and objectively for all allegations including third-party and anonymous reports. Investigations shall be conducted by law enforcement for sexual abuse reports, internal reviews, and investigations of reports of sexual harassment incidents will be reviewed and coordinated by the PREA Coordinator. PREA Coordinator, Program Director or designee shall contact the State Police Department to initiate a criminal investigation when appropriate. Law enforcement will take the lead role in investigations for sexual abuse and CTR staff will cooperate with such investigations and shall endeavor to remain informed about the progress of the investigation. An effort to determine whether staff actions or failures to act contributed to the abuse. Shall be documented in written reports of the review and the findings" (p. 1).

· There were no incidents of sexual abuse to review.

· Correspondence with Connecticut State Police: correspondence with Connecticut State Police confirmed that they would conduct the sexual abuse or criminal related investigations.

Interviews

Agency Head – The interviewed agency head reported that the agency shall ensure that all allegations of sexual abuse or sexual harassment are investigated. The agency has a PREA coordinator and if there is evidence, we will notify the DOC parole officer, and they will turn it over to Connecticut State Police. The state police will conduct the criminal investigation, and our agency will conduct the administrative investigation. All parties are immediately notified of the allegations.

Corrective Actions:

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

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

	115.222 (b). The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its Web site or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website or made publicly available via other means. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that "Investigations into allegations of sexual abuse and sexual harassment shall be done so promptly, thoroughly, and objectively for all allegations including third-party and anonymous reports. Investigations shall be conducted by law enforcement for sexual abuse reports, internal reviews, and investigations of reports of sexual harassment incidents will be reviewed and coordinated by the PREA Coordinator. PREA Coordinator, Program Director or designee shall contact the State Police Department to initiate a criminal investigation when appropriate. Law enforcement will take the lead role in investigations for sexual abuse and CTR staff will cooperate with such investigations and shall endeavor to remain informed about the progress of the investigation. An effort to determine whether staff actions or failures to act contributed to the abuse. Shall be documented in written reports of the review and the findings" (p. 1). · There were no incidents of sexual abuse to review. · The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website or made publicly available via other means at https://ctrenaissance.org/about/licensin-g-accreditation/prea/. Interviews Investigative Staff – The interviewed staff stated all allegations of sexual abuse or sexual harassment are referred to the CT State Police for criminal investigations. Administrative investigations are managed internally.

	Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.222 (c). If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigation entity. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: · The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website or made publicly available via other means at https://ctrenaissance.org/about/licensin-g-accreditation/prea/. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.222 (d). Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations. Auditor is not required to audit this provision. 115.222 (e). Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in community confinement facilities shall have in place a policy governing the conduct of such investigations. Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Following analysis and upon review of additional documentation the site has met compliance with the standard.

115.231	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Training Requirements (Review Date: 2023) Policy: Outline of Training Requirements (Review Date: 2023) Mandated Reporter Training (31) NEO Training Prison Rape Elimination Act PREA Training Pamphlet PREA Training PPT PREA Acknowledgement Signed/Staff PREA Training Understanding (9) PREA Refresher Training (29) Interviews: Random Sample of Staff (12) Findings (By Provision): 115.231 (a). The agency shall train all employees who may have contact with residents on: (1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' rights to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in confinement; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency trains all employees who may have contact with residents on the agency's zero-tolerance policy for sexual abuse and sexual harassment. The agency trains all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. The agency trains all employees who may have contact with residents on the right of residents to be free from sexual abuse and sexual harassment. The agency trains all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment. The agency trains all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in confinement. The agency trains all employees who may have contact with residents on the common reactions of sexual abuse and sexual harassment victims. The agency trains all employees who may have contact with residents on how to avoid inappropriate relationships with residents. The agency trains all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents. The agency trains all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. · Policy: Training Requirements policy provides the agency overview of staff training requirements. · Policy: Outline of Training Requirements: Provides a list of all training requirements for full and part time staff; based on their agency roles and responsibilities. · Mandated Reporter Training: Addresses the roles and responsibilities of Mandated Reporters (31). The auditor reviewed certificates for 31 staff completions. · NEO Training Prison Rape Elimination Act: The PPT is comprehensive training addresses all of the training requirements of the provision. · PREA Training Pamphlet: The pamphlet serves as a comprehensive training pamphlet created by the American Probation and Parole Association on “Preventing and Responding to Corrections-Based Sexual Abuse: A Guide for Community Corrections Professionals.” · PREA Training PPT: General presentation on the PREA standards. · PREA Training PPT: General presentation on the PREA standards. Training Curriculum: The agency training curriculum covers all of the above-mentioned elements. The agency's training curriculum comprehensively covers all necessary topics, including the prevention, detection, reporting, and response to sexual abuse and sexual harassment. This training ensures that staff are well-equipped to uphold

	the rights of residents and employees to be free from abuse and retaliation. · Sample of Training Record: Nine records were reviewed for new hire staff showing the completion of PREA training. A sample of nine training records confirmed the completion of PREA training for new hires, and interviews with randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. Interviews Random Sample of Staff – The twelve staff interviewed confirmed that they received PREA education during onboarding/OJT training and undergo refresher training multiple times a year. This training covers policy updates, employee, and resident rights, recognizing signs of sexual abuse, and reporting and response procedures. They demonstrated knowledge of how to prevent, detect, report, and respond to sexual abuse and harassment, including identifying physical harm, maintaining appropriate boundaries, and recognizing signs such as closed off, quiet, or isolated. Additionally, the staff articulated strategies to prevent inappropriate relationships with resident by avoid sharing personal information, not doing favors for resident and comply with mandated reporting laws. Staff were also able to give examples regarding residents may display anger, avoidance and fear as dynamics and reactions of sexual abuse and sexual harassment. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.231 (b). Such training shall be tailored to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the training is tailored to the gender of the residents at the facility. · Mandated Reporter Training: Addresses the roles and responsibilities of Mandated Reporters · NEO Training Prison Rape Elimination Act: The PPT is comprehensive training addresses all of the training requirements of the provision. · PREA Training Pamphlet: The pamphlet serves as a comprehensive training

	pamphlet created by the American Probation and Parole Association on “Preventing and Responding to Corrections-Based Sexual Abuse: A Guide for Community Corrections Professionals.” · PREA Training PPT: General presentation on the PREA standards. Training Curriculum: The agency training curriculum covers all of the above-mentioned elements. The agency's training curriculum comprehensively covers all necessary topics, including the prevention, detection, reporting, and response to sexual abuse and sexual harassment. This training ensures that staff are well-equipped to uphold the rights of residents and employees to be free from abuse and retaliation. · Sample of Training Record: Nine records were reviewed for new hire staff showing the completion of PREA training. A sample of nine training records confirmed the completion of PREA training for new hires, and interviews with randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.231 (c). All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, in bbetween trainings the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and harassment. The frequency with which employees who may have contact with residents receive refresher training on PREA requirements is annually. · Sample of Training Record: Nine records were reviewed for new hire staff showing the completion of PREA training. A sample of nine training records confirmed the completion of PREA training for new hires, and interviews with randomly selected staff members corroborated their understanding and adherence

	to the zero-tolerance policy. · Refresher Training: Five records were reviewed for existing staff show the completion of PREA Refresher Training. Refresher training occurs bi-annually. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.231 (d). The agency shall document, through employee signature or electronic verification, that employees understand the training they have received. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification. · Training Acknowledgement: The agency ensures that employees who may have contact with residents confirm their understanding of the training received through either a signature or electronic verification. The agency changed the process to electronic and the electronic process does not have an acknowledgement. · Staff PREA Understanding Acknowledgement Signed (9). Sample of Training Record: Nine records were reviewed for new hire staff showing the completion of PREA training. A sample of nine training records confirmed the completion of PREA training for new hires, and interviews with randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.232	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Volunteers and Interns (Review Date: 2023) Training Curriculum (Same as employees 115.231) Interviews: Volunteer(s) or Contractor(s) who may have Contact with Residents Findings (By Provision): 115.232 (a). The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The number of volunteers and individual contractors who have contact with residents who have been trained in agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 4. · Policy: The Volunteers and Interns policy states that “All applicants accepted as Volunteers or Interns shall have a complete orientation and training period that includes at a minimum client rights, security and confidentiality regulations, emergency procedures, lines of communication and authority, information regarding insurance coverage, information about personal risks and liability, and all agency policies and procedures. “(p. 1). If there are volunteers or contractors, the facility will utilize the PREA training curriculum that is used for staff. · There were no volunteers or contractors who may have contact with residents to review records.

	· There were no volunteers or contractors who may have contact with residents to review records. · Training Curriculum (Same as employees 115.231) Interviews Volunteer(s) or Contractor(s) who may have Contact with Residents – There were no contracted staff during the onsite audit. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.232 (b). The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents have been notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. It was further reported that all volunteers and contracts receive the same training as employees. · Training Curriculum (Same as employees 115.231) Interviews: Volunteer(s) or Contractor(s) who may have Contact with Residents – There were no contracted staff during the onsite audit. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and

	review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.232 (c). The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received. Compliance Determination The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains documentation confirming that volunteers and contractors who have contact with residents understand the training they have received. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.233	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act (Review Date: 2025) Client PREA Brochure Acknowledgement (English/Spanish) Carelogic Client PREA Brochure Acknowledgement (20) PREA Brochure (English/Spanish)

	12 Month Roster Resident Handbook Interviews: Intake Staff (2) Resident (10) Findings (By Provision): 115.233 (a). Residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The number of residents admitted during past 12 months who were given this information at intake: 220. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Policy: Prison Rape Elimination Act states that “During the admission process, all individuals in the custody of the Judicial Branch or Department of Correction are provided information about Connecticut Renaissance’s zero-tolerance policy along with instructions for reporting a complaint.” (p. 3). · Client PREA Brochure Acknowledgement (English/Spanish)-sample · Carelogic Client PREA Brochure Acknowledgement (20). The facility provides PREA education to residents during intake and follows up with more comprehensive education within the required 30-day timeframe. Materials reviewed—including intake forms, resident handbooks, posters, —are presented in formats accessible to residents of varying literacy levels, and are available in multiple languages as needed. · PREA Brochure (English/Spanish): provided to residents at intake addressing how to report sexual assault, defining sexual abuse/harassment/voyeurism; your rights, help for victims and families, defining PREA, and contact information on how to report. · Resident Handbook: The resident handbook provides residents information on the site rules related to sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. · 12-month roster of residents

Site Review:

Observations Related to Intake Procedures and Accessibility of PREA Education:

The auditor confirmed that a designated peer support specialist conducts the facility's intake process. To assess the intake procedure, the auditor participated in a mock demonstration with the intake staff, observing the delivery of PREA education and related materials.

Written information provided during intake was reviewed and found to be clear, concise, and presented at an appropriate reading level. The facility ensures that this information is accessible to all individuals, including those who are Limited English Proficient (LEP), by offering written materials in the most commonly spoken languages within the facility. In addition, translation and interpretation services are readily available on demand to accommodate non-English speaking residents.

The facility also provides interpreter support for individuals who are Deaf or hard of hearing. Staff are trained and prepared to read PREA-related materials aloud when necessary to accommodate residents who are blind, have low vision, or possess limited reading skills. For individuals with cognitive or functional disabilities, mental health professionals or other trained staff assist in delivering and reinforcing the required PREA information to ensure comprehension.

Informal conversations with both staff and residents confirmed that staff routinely read through the PREA education materials with residents, actively encouraging questions and confirming understanding. This demonstrates an initiative-taking approach to ensuring all residents receive and comprehend the information necessary to support their safety and rights under PREA.

INTERPRETATION SERVICES

Observations Related to Language Access and Interpretation Services:

During the site review, the auditor assessed the facility's procedures for providing language access and securing interpretation services. The auditor independently contacted the contracted telephonic interpretation service (Language Line) and confirmed that it was functional and accessible. Services were available immediately upon request, and no personal identification was required from residents to utilize the service—only an agency-specific access code.

Although the use of the Language Line must be coordinated through the Director due to associated costs, the facility mitigates this by ensuring residents have immediate access to multiple bilingual staff members, particularly for Spanish—the

	most commonly spoken non-English language among the resident population. Additionally, residents have access to personal cell phones, which may facilitate communication needs in a variety of languages, although official interpretation for PREA-related matters must still follow agency-approved channels. Informal conversations with staff revealed that the agency employs a bilingual case manager who is based at another program within the facility complex and is accessible as needed. Several staff members onsite also speak Spanish and are available to assist with communication. Case managers interviewed were able to clearly articulate the procedure for requesting interpreter services and expressed confidence in accessing support if a resident with limited English proficiency required assistance. These findings indicate that the facility has effective systems in place for ensuring meaningful access to communication for limited English proficient residents, consistent with PREA standards. Interviews: Intake Staff – The interviewed intake staff reported that the PREA screening is conducted on day one. During intake staff I will go over the zero-tolerance policy, how to make a report, and how to report everything. Resident Interview Questionnaire – All of the interviewed residents reported that when they first arrived at the facility there were given the rules against sexual abuse and sexual harassment. When probed the residents stated that the staff went over paperwork with them, and this occurred within the same day of placement. This information was conveyed through a one-on-one conversation with a staff member, and each resident was also given forms to sign acknowledging their understanding of the rules. Seven residents stated that during their initial intake at the facility, they were informed about their rights to be protected from sexual abuse and harassment, the process for reporting such incidents to staff or hotline number, and their right to do so without facing retaliation or punishment. Three residents stated they do not recall all of the questions being asked when met with staff. Six of the ten residents interviewed reported that this information was covered with them within two weeks of arriving at the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.233 (b). The agency shall provide refresher information whenever a resident is transferred to a different facility. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides residents who are transferred from a different community confinement facility with refresher information referenced in 115.233(a)-1. The number of residents transferred from a different community confinement facility during the past 12 months: 0. The number of residents transferred from a different community confinement facility, during the past 12 months, received refresher information: 0. · Policy: The Admission and Orientation Policy states that “PREA Acknowledgement - Residents shall receive information explaining CT Renaissance’s zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents and the review process. Such information shall be provided as a refresher whenever a resident is transferred to another facility” (p. 2). N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Interviews The interviewed intake staff reported that the PREA screening is conducted on day one. During intake staff I will go over the zero-tolerance policy, how to make a report, and how to report everything. Residents are provided the information within 72 hours. Resident Interview Questionnaire – Ten residents were interviewed, all of whom had been at the placement for less than 12 months. Additionally, six of these residents were transferred from a jail, hospital, detox center or recovery center to the facility. All residents reported receiving PREA education upon intake. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.233 (c). The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, otherwise disabled, as well as to residents who have limited reading skills.

Compliance Determination:

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

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

· Policy: The Admission and Orientation policy states that “Staff shall review and approve the orientation documents. Staff shall provide support to the clients with language / literacy difficulties” (p. 2).

· PREA Brochure (English/Spanish): provided to residents at intake addressing how to report sexual assault, defining sexual abuse/harassment/voyeurism; your rights, help for victims and families, defining PREA, and contact information on how to report. The brochures are available in the most common languages of English and Spanish.

Corrective Actions:

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

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

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

Compliance Determination:

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

· As reported in the PAQ, the agency maintains documentation of resident participation in PREA education sessions.

· Policy: Prison Rape Elimination Act states that “During the admission process, all individuals in the custody of the Judicial Branch or Department of Correction are provided information about Connecticut Renaissance’s zero-tolerance policy along with instructions for reporting a complaint.” (p. 3).

· Client PREA Brochure Acknowledgement (English/Spanish)

	· Carelogic Client PREA Brochure Acknowledgement (20). The facility provides PREA education to residents during intake and follows up with more comprehensive education within the required 30-day timeframe. Materials reviewed—including intake forms, resident handbooks, posters, —are presented in formats accessible to residents of varying literacy levels, and are available in multiple languages as needed. · PREA Brochure (English/Spanish): provided to residents at intake addressing how to report sexual assault, defining sexual abuse/harassment/voyeurism; your rights, help for victims and families, defining PREA, and contact information on how to report. · 12-month roster of residents Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.233 (e). In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. · PREA Brochure (English/Spanish): provided to residents at intake addressing how to report sexual assault, defining sexual abuse/harassment/voyeurism; your rights, help for victims and families, defining PREA, and contact information on how to report. · Posting (Spanish/English) Site Review: Observations Related to PREA Signage, Visibility, and Accessibility of Information: During the onsite inspection, the auditor observed that PREA-related materials—including posters, resident handbooks, brochures, and information on advocacy services—were prominently displayed throughout the common areas of

	each facility location. This information was accessible to both residents and visitors and was presented in both English and Spanish, reflecting the linguistic needs of the population served. The auditor conducted a comprehensive review of the facility's signage to assess whether critical information about sexual safety and available support services was effectively communicated. The evaluation considered multiple factors, including readability, accessibility, accuracy, consistency, and strategic placement. Readability and Accessibility: The language used in signage was clear, concise, and easy to understand. Information regarding available services and how to access them was clearly outlined. Materials were translated into Spanish, the most commonly spoken non-English language within the facility. Signage formatting, including text size and layout—was suitable for a broad range of readers, including individuals with visual impairments or physical limitations. Accuracy and Consistency: The content displayed on PREA materials was found to be accurate and consistent across all observed areas. The auditor evaluated phone numbers listed for service providers and advocacy organizations to confirm functionality. Audit-specific notices were current and displayed accurate contact information for applicable external support entities. Placement: PREA signage was placed in highly visible and accessible locations throughout the facility, including housing units, multipurpose rooms, break rooms, and staff dining areas. Information was also posted in visitor-accessible areas, reinforcing transparency and outreach to the broader community. In addition to direct observation, the auditor conducted informal conversations with residents and staff regarding the visibility and permanence of PREA materials. The residents reported that there are signs everywhere throughout the facility. Corrective Actions: Resident Education: The residents are not fully aware of what victim advocacy and emotional support services entail. It is recommended that the residents receive additional information on victim advocacy and emotional support services. Current Residents received additional information on victim advocacy and emotional support, additionally the agency added the information to the facility resident education. Ø Corrective action taken: the facility add information on victim advocacy and emotional support to the resident handbook. Staff Education: The facility must educate staff members, including intake staff,

	about victim advocacy and emotional support services. This training must cover detailed information about the services available. Documentation verifying that staff have received this education must be provided. Ø Corrective Action Taken: Additional training was provided to staff. Intake: The facility must provide documentation confirming that information about victim advocacy and emotional support services is included in the intake process. Additionally, staff must be trained to explain the scope of services offered by the designated advocacy center associated with the facility. Ø Corrective Action Taken: Additional training was provided to staff. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. All corrective measures were taken. Based on analysis, the facility is compliant with all provisions in this standard.

115.234	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Training Requirements (2023) Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) (1) Training Certificate (PREA Coordinators' Your Roles and Responsibilities) Interviews:

Investigative Staff

Findings (By Provision):

115.234 (a). In addition to the general training provided to all employees pursuant to § 115.231, the agency shall ensure that, to the extent the agency conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.

Compliance Determination:

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

· As reported in the PAQ, the agency policy does not require that investigators are trained in conducting sexual abuse investigations in confinement settings.

· Policy: Training Requirements states that “The agency PREA coordinator and any staff conducting PREA investigations will complete training in conducting sexual abuse investigations in confinement settings (NIC PREA: Investigating Sexual Abuse in a Confinement Setting or equivalent)” (p. 1).
· Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) (1): the certificate provides verification of the staff completion of training.

· Training Certificate (PREA Coordinators Your Roles and Responsibilities) (1): the certificate provides verification of the staff completion of training.

Interviews

Investigative Staff – The interviewed staff stated that they have completed the NIC training courses called PREA: Investigating Sexual Abuse in a Confinement Setting and PREA: Coordinators’ Roles and Responsibilities.

Corrective Actions:

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

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

115.234 (b). Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to

	substantiate a case for administrative action or prosecution referral. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) · Training Certificate (Your Role Roles and Responsibilities) Interviews: Investigative Staff – The interviewed staff stated that the training topics included in the training were: PREA Investigative Standards, Criteria and Evidence for Administrative Action and Prosecution, the Role of Medical and Mental Health in the Investigative Process, Roles of the Victim Advocate, Working with Victims, Proper use of Miranda and Garrity Warnings, Sexual Abuse Evidence Collection in Confinement Settings, Interviewing Techniques, and Institutional Culture and Investigations. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.234 (c). The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains documentation showing that investigators have completed the required training. The number of investigators currently employed who have completed the required training: 2. · Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) (1): the certificate provides verification of the staff completion of training. · Training Certificate (PREA Coordinators Your Roles and Responsibilities) (1): the certificate provides verification of the staff completion of training.

	Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.234 (d). Any State entity or Department of Justice component that investigates sexual abuse in confinement settings shall provide such training to its agents and investigators who conduct such investigations. Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.235	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Specialized Training for Medical and Mental Health Staff (3) Interviews: Medical and Mental Health Staff (2) Findings (By Provision): 115.235 (a). The agency ensures that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: (1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · N/A-As reported in the PAQ, the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The number of all medical and mental health care practitioners who work regularly at this facility and have received the training required by agency policy: 0. The percent of all medical and mental health care practitioners who work regularly at this facility and have received the training required by agency policy: 0. · Training Records (3). The facility provides comprehensive PREA training to all medical and mental health staff, ensuring that they are equipped to fulfill their responsibilities under PREA. Training records, including certificates of completion, lesson plans, and attendance logs, confirm that practitioners have received instruction in key areas, including: o How to detect and assess signs of sexual abuse and sexual harassment; o How to preserve physical evidence in cases of sexual abuse; o How to conduct medical and mental health assessments in a trauma-informed manner; o How and when to report allegations of sexual abuse in compliance with mandatory reporting laws and agency policy. · Interviews with medical and mental health staff confirmed their understanding of PREA requirements, their role in responding to allegations, and the importance of preserving victim confidentiality and evidence integrity. Interviews: Medical and Mental Health Staff: The staff interviewed reported that they received the above specialized training, and it was taken online. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.235 (b). If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency medical staff at this facility do not conduct forensic medical exams. Interviews: Medical and Mental Health Staff – The interviewed staff reported that they do not conduct forensic interviews. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.235 (c). The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has onsite medical and/or mental health staff, however it further states n/a on maintaining documentation of training records. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.235 (d). Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.231 or for contractors and volunteers under § 115.232, depending upon the practitioner's status at the agency. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: PREA Training (3). The auditor review of records confirmed that the three staff completed annual PREA Training

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

115.241	**Screening for risk of victimization and abusiveness**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Screening for Risk of Victimization and Abusiveness (Review Date: 2021) Policy: Admission and Orientation PREA Screening (Paper Version)-Sample PREA Screening Carelogic (20) PREA Screening Carelogic Rescreening (15) Corrective Action Documents: Assessments/Reassessments Interviews: Staff Responsible for Risk Screening (2) Resident Interview Questions (10)

	PREA Coordinator Findings (By Provision): 115.241 (a). All residents shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. · Policy: The Screening for Risk of Victimization and Abusiveness policy states that “The PREA Screening Assessment shall be conducted with the client within 72 hours of admission” (p. 1). · Policy: The Admissions and Orientation policy also reiterates the requirements to complete an assessment upon intake (p. 2). Site Review: Observations Related to PREA Signage and Risk Screening Process: During the site review, the auditor observed that PREA informational signage was present in the main public areas of the facility. There was visible signage throughout the facility. The auditor also conducted a comprehensive review of the facility’s PREA risk screening process, including observation of a mock demonstration. The following key components were assessed: Identification of Screening Personnel: The auditor confirmed that designated intake staff (peer support specialist) are responsible for administering the PREA risk screening. This verification ensured that follow-up interviews could be appropriately directed to the correct personnel. Intake staff were observed directly engaging residents and administering intake questions. Screening Environment and Privacy: The screening process was evaluated to determine whether it was conducted in a manner that preserved the confidentiality of the resident. It was observed that screenings took place in settings where conversations could not be overheard by unrelated staff or other residents, thus minimizing the potential for breaches of sensitive information. Staff Engagement and Communication: The approach taken by intake staff during

	the screening was also assessed. Staff demonstrated a patient and supportive demeanor, taking care to rephrase or rearticulate questions as needed to ensure resident comprehension and comfort. This approach contributed to a respectful and trauma-informed environment. To further assess compliance, the auditor engaged in informal conversations with both staff and residents about their experiences with the screening process. These discussions provided useful insights into the functionality of the screening tool, the methods of information collection, and the degree of privacy maintained during the process. Residents reported feeling comfortable during the screenings and expressed that staff conducted the process respectfully, encouraging honest and open responses. Interviews Staff Responsible for Risk Screening – The interviewed staff reported that the risk of sexual victimization or risk of sexual abuse is done at intake. Intake is typically done immediately when a client arrives but no more than 72 hours. Resident Interview Questionnaire – All of the interviewed residents reported that the facility they were asked questions like whether or not they had been in jail or prison before, whether they have been sexually abused, whether they identify as gay, lesbian, bisexual, or whether they may be in danger of sexual abuse. Eight residents queried about their initial arrival to facility and if they were asked about experiences such as past sexual abuse, their sexual orientation (gay, lesbian, bisexual, or transgender), any disabilities, and their perception of being at risk for sexual abuse all recalled being asked these questions the day of arrival or within the week. Two of the ten residents do not recall being asked this question. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.241 (b). Intake screening shall ordinarily take place within 72 hours of arrival at the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According to the PAQ, the policy requires that residents be screened for risk of sexual victimization or risk of sexual abuse of other residents within 72 hours of their intake. The number of residents entering the facility (either through intake or

transfer) within the past 12 months (whose length of stay in the facility was for 72 hours or more) who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 190.

· Policy: The Screening for Risk of Victimization and Abusiveness policy states that “The PREA Screening Assessment shall be conducted with the client within 72 hours of admission” (p. 1).

· PREA Screening Risk Assessment (20) The auditor reviewed the PREA Screening Risk Assessment verifying that the risk screenings were conducted within 72 hours of the admission. The auditor compared the risk screening with the placement date. A random set of residents were selected from the auditor to review.

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the risk of sexual victimization or risk of sexual abuse is done at intake. Residents are screened and we ask about their safety needs, perception of vulnerability, perceived sexual orientation of resident, and sexual orientation.

Resident Interview Questionnaire – All of the interviewed residents reported that the facility they were asked questions like whether or not they had been in jail or prison before, whether they have been sexually abused, whether they identify as gay, lesbian, bisexual, or whether they may be in danger of sexual abuse. Eight residents queried about their initial arrival to facility and if they were asked about experiences such as past sexual abuse, their sexual orientation (gay, lesbian, bisexual, or transgender), any disabilities, and their perception of being at risk for sexual abuse all recalled being asked these questions the day of arrival or within the week. Two of the ten residents do not recall being asked this question.

Corrective Actions:

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

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

115.241 (c). Such assessments shall be conducted using an objective screening instrument.

Compliance Determination:

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

· As reported in the PAQ, the facility uses a risk assessment which is conducted using an objective screening instrument.

	· The auditor reviewed the Risk Assessment, and it was determined that the site is using an objective screening instrument. Objectivity was determined based on the following: o Standardized Criteria: It uses pre-determined, clear, and measurable criteria for evaluating risk. o Consistent Application: The instrument is applied uniformly to all individuals being assessed, ensuring that each person is evaluated using the same criteria and process. o Quantifiable Metrics: There is a numerical scoring system with clearly defined categories to measure risk, reducing reliance on personal judgment. · PREA Screening Risk Assessment (20) The auditor reviewed the PREA Screening Risk Assessment verifying that the risk screenings were conducted within 72 hours of the admission. The auditor compared the risk screening with the placement date. A random set of residents were selected from the auditor to review. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.241 (d). The intake screening shall consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (1) Whether the resident has a mental, physical, or developmental disability; (2) The age of the resident; (3) The physical build of the resident; (4) Whether the resident has previously been incarcerated; (5) Whether the resident's criminal history is exclusively nonviolent; (6) Whether the resident has prior convictions for sex offenses against an adult or child; (7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the resident has previously experienced sexual victimization; and (9) The resident's own perception of vulnerability Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · PREA Screening Risk Assessment (20) The auditor reviewed the PREA Screening Risk Assessment verifying that the risk screenings were conducted within 72 hours of the admission. The auditor compared the risk screening with the

placement date. A random set of residents were selected from the auditor to review.

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the screening assesses the age, build, criminal history (including non-violent sex offenses), whether the resident has any disabilities, previous incarcerations, their perceived sexual orientation, and perception of vulnerability. It was further stated that the staff ask the questions to the residents.

Corrective Actions:

PREA Screening Risk Assessment: While the facility consistently utilized the PREA Screening Risk Assessment on residents upon admission to the facility, the tool did not ask if a resident identified as intersex or gender non-conforming. The facility shall update the tool and provide documentation that is being utilized with the new intakes.

Ø Corrective Action Taken: The facility updated the screening tool to add the additional language for intersex and gender non-conforming.

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

Compliance Determination:

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

PREA Screening Risk Assessment has a section that addresses any prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse.

Interviews

Staff Responsible for Risk Screening – The interviewed staff reported that the screening assesses the age, build, criminal history (including non-violent sex offenses), whether the resident has any disabilities, previous incarcerations, their perceived sexual orientation, and perception of vulnerability. It was further stated that the staff ask the questions to the residents.

Corrective Actions:

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

Discussion: A review of the appropriate documentation, interviews with staff, and

	review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.241 (f). Within a set time period, not to exceed 30 days from the resident's arrival at the facility, the facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the policy requires that the facility reassess each resident’s risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident’s arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The number of residents entering the facility (either through intake or transfer) within the past 12 months whose length of stay in the facility was for 30 days or more who were reassessed for their risk of sexual victimization or of being sexually abusive within 30 days after their arrival at the facility based upon any additional, relevant information received since intake: 152. · Policy: Screening for Risk of Victimization and Abusiveness states that “within 30 days of admission, the program will reassess the resident’s risk of victimization for abusiveness based upon any additional relevant information received by the facility since the intake screening” (p. 2). · PREA Risk Screening re-assessment (14). It should be noted that the auditor randomly selected assessments to review. Of the 20 randomly selected assessments, 6 of the residents were removed from the program prior to the 30 days. · The facility has a clearly defined procedure for conducting timely risk reassessments using a standardized screening tool consistent with the initial intake screening. Documentation reviewed confirmed that reassessments are consistently completed within the 30-day window following intake and are also conducted when additional information is received—such as disciplinary infractions, behavioral changes, or reports of sexual abuse or harassment. There was only one identified assessment conducted a few days later. · The reassessment forms are thorough and consider the required risk factors, including prior victimization, age, physical build, criminal history, and mental health status. Reviewed case files demonstrated appropriate updates to housing, programming, and supervision decisions based on reassessment outcomes, aligning with PREA’s goal of individualized, risk-informed placement. Interviews Staff Responsible for Risk Screening – The interviewed staff reported that the initial

	screening occurs immediately upon intake and the residents are reassessed within 30 days. Resident Interview Questionnaire – Ten residents were interviewed. Eight residents stated they have not been asked again about their prior sexual abuse, their sexual orientation, any disabilities or if they feel at risk of sexual abuse while in placement since their arrival. Two residents stated that they have been asked these questions again during a recent assessment session. Corrective Actions: PREA Screening Risk Assessment: While the facility consistently utilized the PREA Screening Risk Assessment on residents upon admission to the facility, the tool did not ask if a resident identified as intersex or gender non-conforming. The facility shall update the tool and provide documentation that is being utilized with the new intakes. Ø Corrective Action Taken: The facility updated the screening tool to add the additional language for intersex and gender non-conforming. 115.241 (g). A resident's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the policy requires that a resident’s risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness. · Policy: Screening for Risk of Victimization and Abusiveness states that “a residents risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse or receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness” (p. 3). · There were no identified incidents of allegations of sexual abuse during the reporting period. Interviews Staff Responsible for Risk Screening -The interviewed staff reported that reassessments occur within maybe 90 days. The intake does not do the rescreening.

	Resident Interview Questionnaire – Ten residents were interviewed. Eight residents stated they have not been asked again about their prior sexual abuse, their sexual orientation, any disabilities or if they feel at risk of sexual abuse while in placement since their arrival. Two residents stated that they have been asked these questions again during a recent assessment session. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.241 (h). Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) the questions regarding: (a) whether or not the resident has a mental, physical, or developmental disability; (b) whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; (c) Whether or not the resident has previously experienced sexual victimization; and (d) the resident's own perception of vulnerability. · Policy: Screening for Risk of Victimization and Abusiveness states that "Residents may not be disciplined for refusing to answer, or for not disclosing complete information" (p. 3). Interviews Staff Responsible for Risk Screening – The interviewed staff reported that residents are not disciplined for refusing to answer any portions of the assessment tool. Corrective Actions: N/A. There are no corrective actions for this provision. 115.241 (i). The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the residents' detriment by staff or other residents. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: Site Review: Assessment of Information and Documentation Storage Practices: During the site review, the auditor conducted a thorough assessment of the facility's information and documentation storage practices to ensure compliance with PREA standards regarding the confidentiality and security of sensitive information. Physical Storage of Documentation: The auditor observed the storage of client information, which was securely stored in the locked office of the assigned case manager. This ensured that sensitive data, including but not limited to risk screening information, medical records, and sexual abuse allegations, was kept in a secure, restricted area. Security of Physical Storage Areas: The physical storage areas were evaluated to determine the level of security in place. The auditor specifically looked for mechanisms, such as key access, to restrict unauthorized access to hard copy documentation. It was confirmed that access to these areas was appropriately controlled to maintain confidentiality. Electronic Information Safeguards: In addition to reviewing physical storage practices, the auditor also examined the facility's electronic safeguards for information stored electronically, including risk screening data. The auditor assessed the measures implemented to secure electronic access to sensitive information, ensuring that only authorized personnel had access to these records. Conclusion: The facility has implemented appropriate security measures for both physical and electronic storage of sensitive documentation. Access to these areas is restricted and well-controlled, in compliance with PREA standards to safeguard resident privacy and confidentiality. Interviews Staff Responsible for Risk Screening – The interviewed staff reported that the assessment tools are kept with the intake staff that completes it along with the clinician. PREA Coordinator: The staff interviewed reported that information is accessible only to those tasked with monitoring client safety. Information received is used from a programmatic perspective in determining service needs and ensuring the safety of the resident. We have controls in place to ensure that information is appropriately used and ensure that staff or other residents do not exploit sensitive information. Employees, volunteers, interns, or contractors found to be using sensitive information to the detriment of the resident will be subject to corrective action including termination.

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

115.242	**Use of screening information**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Screening for Risk of Victimization and Abusiveness (Review date 2021) Policy: Evaluation and Intake Interview (Review date 2023) Facility Layout Programming Placement Risk Assessment (20) Interviews: PREA Coordinator Staff Responsible for Risk Screening (1) Findings (By Provision): 115.242 (a). The agency/facility uses information from the risk screening required

by §115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.

Compliance Determination:

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

· A reported in the PAQ, the agency/facility uses information from the risk screening required by §115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping those residents separate at high risk of being sexually victimized from those at high risk of being sexually abusive.

· Policy Screening for Risk of Victimization and Abusiveness states that "Information received during the screening / evaluation process shall uphold all of CT Renaissance's standards of confidentiality. Information received shall be used from a programming and treatment perspective in determining service needs and ensuring the safety of the resident. Employees, volunteers, interns, or contractors found to be using sensitive information to the detriment of the resident shall be the subject of corrective action up to and including termination" (p. 3).

· Policy: The Evaluation and Intake Policy further reiterates the usage of assessment material for programming and placement.

· The facility provided a comprehensive layout of the entire premises and the location of residents.

· The auditor reviewed the risk screening for 20 randomly selected residents along with the risk screening for a transgender resident. As reported by the intake staff the information from the screening is used to determine placement in the facility. The facility does not conduct any programming or job assignments at the facility.

· The facility leadership and admissions staff was able to articulate how residents' housing determination is done on a case-by-case basis; incorporating the health and safety, potential security management concerns and resident on views. The facility provided examples of current assessment where a transgender resident was housed in accordance with their safety needs and not by default based on gender identity or sex assigned at birth. The same practice is utilized for other residents who were considered vulnerable or at risk.

Interviews

PREA Coordinator – The interviewed staff reported that all residents are assessed during the intake and evaluation process for their risk of being sexually abused by other residents or sexually abused towards. CT Renaissance uses the Screening Assessment for Vulnerability to Victimization and Sexually Aggressive Behavior

(VSAB) tool and clients receive this screening within 72 hours of admission. The screening tool is scored and utilized to make housing, monitoring and treatment or service decisions/recommendations. In addition, if the resident is identified as a vulnerable victim or sexually aggressive, it will be noted in the POP sheet to assist staff in monitoring them. Within 30, the program will be reassessed.

Staff Responsible for Risk Screening – The interviewed staff reported that the information is used to ensure resident safety.

Corrective Actions:

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

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

115.242 (b). The agency shall make individualized determinations about how to ensure the safety of each resident.

Compliance Determination:

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

· As reported in the PAQ, the agency/facility makes individualized determinations about how to ensure the safety of each resident.

· Policy Screening for Risk of Victimization and Abusiveness states that "Information received during the screening / evaluation process shall uphold all of CT Renaissance's standards of confidentiality. Information received shall be used from a programming and treatment perspective in determining service needs and ensuring the safety of the resident. Employees, volunteers, interns, or contractors found to be using sensitive information to the detriment of the resident shall be the subject of corrective action up to and including termination" (p. 3).

· Policy: The Evaluation and Intake Policy further reiterates the usage of assessment material for programming and placement.

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

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

	Interviews: Staff Responsible for Risk Screening – The interviewed staff reported that the information is used to ensure resident safety. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.242 (c). In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency/facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. · Policy: The Screening for Risk of Victimization & Abusiveness states that “Bed placements for transgender or intersex residents shall be based on concerns for resident’s health hand safety. The transgender or intersex resident’s own view of safety needs shall be a serious consideration in making bed placements. However, the program shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated areas solely on the basis of such identification or status, unless such placement is in a dedicated area established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents. Documentation of placement considerations shall be maintained in the” (p. 3). Interviews PREA Coordinator – The interviewed staff reported that housing and program assignments are made on a case-by-case basis, based on information from the PREA Screening and the client at intake. A variety of housing configurations are available based on need and preference. The agency prioritizes resident health and safety when making placement decisions and utilizes a client-centered approach across all services. The agency accepts referrals to Work Release within our admission criteria and as per our contract with DOC. Any management or security problems would be

addressed on an individual basis, in coordination with DOC, and managed accordingly, with the joint goals of ensuring safety while facilitating client access to the program.

Transgender/Intersex Residents – There were no identified transgender or intersex residents.

Corrective Actions:

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

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

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

Compliance Determination:

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

· As reported in the PAQ, the placement and program assignment of transgender and intersex residents are reassessed every six months to review any threats to safety experienced by the resident. It should be noted that there were no transgender or intersex residents housed at the facility during the audit period.

Interviews

PREA Coordinator – The interviewed staff reported that A transgender or intersex resident’s own view with respect to his or her own safety would be given the highest consideration in placement and programming assignments.

Staff Responsible for Risk Screening – The interviewed staff reported that a transgender person or intersex residents own views of his or her own safety would be given consideration and re-consider all housing/bed assignments.

Transgender/Intersex Residents – There were no identified transgender or intersex residents.

Corrective Actions:

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

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

	115.242 (e). Transgender and intersex residents shall be given the opportunity to shower separately from other residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Policy: The Screening for Risk of Victimization & Abusiveness states that "Transgender and intersex residents shall be given the opportunity to shower separately from other residents" (p. 3). · Audit Site Review: When conducting the onsite inspection there was no indication that the site had separate living units for transgender or intersex residents. Interviews PREA Coordinator – The interviewed staff reported that the facility has a configuration that allows for private showering for a transgender or intersex resident. Staff Responsible for Risk Screening – The interviewed staff reported that a transgender person or intersex residents own vies of his or her own safety would be given consideration and re-consider all housing/bed assignments. Transgender/Intersex Residents – There were no identified transgender or intersex residents. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.242 (f). The agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · While the facility did not have a file to review, the auditor was able to observe

	the process from another site location. Interviews PREA Coordinator – The interviewed staff reported that the agency is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, or wing for lesbian, gay, bisexual, transgender, or intersex residents. The policy fosters an inclusive environment. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.251	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reporting of Sexual Abuse or Harassment (Review Date: 2025) Orientation Checklist with Supervisor Resident Handbook PREA Visitor Rules Interviews:

Random Sample of Staff (12)

Resident Interview Questionnaire (10)

Findings (By Provision):

115.251 (a). The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

Compliance Determination:

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

· As reported in the PAQ, the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: (a) sexual abuse or sexual harassment; (b) retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and (c) staff neglect or violation of responsibilities that may have contributed to such incidents.

· Policy: Reporting of Sexual Abuse or Harassment states that “Staff shall report to their next level Supervisor and the agency’s PREA Coordinator any knowledge or suspicion of sexual abuse and/or harassment against a client / resident by another client/resident, employee, volunteer, intern, or contractor. Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents should also be reported. • Staff shall utilize the PREA Incident report form on behalf of the client / resident to initiate a response by the PREA Coordinator. • Staff may make such reports in a private manner of which they are comfortable. Such reports of sexual abuse, harassment, known retaliation, or concerns of neglect on the part of another staff, volunteer, intern, or contractor may be submitted in writing or verbally to the PREA Coordinator and may be done so anonymously” (p. 1).

· Resident Handbook: The resident handbook provides residents information on the site rules related to sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment.

Site Review:

Observations Related to Reporting Mechanisms, Mail Processes, and Secure Documentation Practices:

As part of the site review, the auditor conducted a comprehensive assessment of the facility’s systems and practices related to internal and external reporting, mail procedures, and the secure storage of sensitive records.

	Reporting Systems and Functionality: The auditor evaluated the facility's reporting system by submitting a report using the same platform accessible to residents (via phones and computers). It was confirmed that residents have access to both facility-provided telephones and their personal cell phones. The facility's response to the test report was reviewed, and documentation of receipt was requested and verified. Electronic reporting devices were assessed for functionality, accessibility, and privacy protections. Devices were operational and appropriately maintained, and accommodations were noted for residents with special needs, including those requiring privacy to report sensitive information. Resident and Staff Awareness of Reporting Procedures: Informal interviews with both staff and residents confirmed awareness of the available reporting methods, including verbal reports. Residents demonstrated understanding of how to report incidents verbally, and staff described appropriate procedures for receiving and documenting these reports. Additionally, it was confirmed that residents have consistent access to writing instruments, paper, and report forms, and the facility supports anonymous written reports, including for incidents occurring prior to admission. Mail and Confidential Communication: The auditor observed mail handling processes and engaged staff and residents in conversations about the privacy and security of correspondence. Residents utilize the U.S. Postal Service to send mail and drop boxes or staff collection methods are used to route outgoing correspondence. Staff confirmed awareness of the confidentiality protocols in place. Storage of Documentation: The physical storage of sensitive hard copy records—including PREA risk screening forms and medical files—was examined. All records were securely stored in locked cabinets or rooms inaccessible to unauthorized individuals, ensuring confidentiality. Signage and Access to Support Services: PREA Audit Notices and signage regarding confidential external support services were prominently displayed throughout the facility, including in housing units, common areas, entrances, visitation spaces, and staff-only areas. These notices were consistently presented in both English and Spanish and were legible and accessible to staff, residents, and visitors. Additionally, signage outlining procedures for reporting sexual abuse or sexual harassment was observed in living areas, programming spaces, and visitation zones, reinforcing the facility’s commitment to safety and transparency. Multiple Reporting Avenues: The auditor confirmed that the agency provides residents with multiple, private, and secure options to report incidents of sexual abuse, harassment, retaliation, or staff misconduct. These include the use of personal or facility phones, written reports,

	internal grievance processes, and direct reporting to staff. Residents demonstrated familiarity with these options and were able to explain the process, including how reports are managed. Overall, the facility demonstrated a strong commitment to ensuring that all individuals confined within the facility have access to clear, confidential, and effective reporting avenues, as well as secure documentation and communication systems. Interviews The twelve staff reported that the resident can privately report by notifying staff, calling the number on the poster, or writing a grievance. Two staff mentioned that residents are able to call PREA Hotline privately in the evening when they have access to their own cellphones and there is a house phone that residents can use during the day. Resident Interview Questionnaire - The interviewed residents reported that they are aware of multiple methods to report sexual abuse or sexual harassment. They felt comfortable reporting incidents to staff and noted additional options, including calling PREA Hotline, filing written note to staff, texting staff, calling the program director, notifying PREA Coordinator Katie, notifying their probation officer, or asking a family member to report on their behalf. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.251 (b). The agency shall also inform residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Compliance Determination: · As reported in the PAQ, the agency shall also inform residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Staff are required to document verbal reports. · Policy: Reporting of Sexual Abuse or Harassment states that “Clients / Residents may make verbal or written reports of sexual abuse or harassment to their Clinician, Program Director, PREA Coordinator, Director of Quality Improvement

	or any other employee they feel comfortable in reporting sexual abuse or sexual harassment; Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and, staff neglect or violation of responsibilities that may have contributed to such incidents. • Staff must allow the client / resident a private area to report their concerns and make their report. Staff must accept both verbal and/or written incident reports. If the client / resident is willing to make a written report, the PREA incident report form should be utilized. If not, the staff person taking the report can write the report" (p. 1). · PREA Brochure: The PREA Brochure (115.333), provides residents with multiple ways to make a report. Site Review Assessment of Facility Signage and Third-Party Reporting Mechanisms: During the onsite audit, the auditor conducted a comprehensive review of facility signage and third-party reporting systems to evaluate compliance with PREA standards and ensure that critical sexual safety information was accessible, accurate, and effectively communicated to staff, residents, and external parties. Signage Readability and Accessibility: The auditor carefully evaluated facility signage for clarity, readability, and accessibility. Signage language was reviewed to ensure it was written at an appropriate reading level—determined to be at or near the 5th grade level—and that it clearly communicated essential information related to PREA, including access to emotional support services and external reporting mechanisms. Multilingual Access: Signage was observed to be available in both English and the most commonly spoken languages within the facility population, effectively supporting residents with limited English proficiency. Design and Placement: Particular attention was paid to the font size, layout, and physical placement of signage. The auditor confirmed that signage was positioned to be easily visible and accessible to individuals of varying heights and abilities, including those with visual impairments or physical disabilities. Placement was confirmed throughout resident living areas, common spaces, staff-only zones, and areas accessible to the public. Accuracy and Consistency: Facility signage was reviewed for accuracy and consistency. Audit-related postings were up to date, and contact information for external agencies, such as the Department of Corrections and the Connecticut State Police, was verified. The auditor was able to confirm that both entities were accessible and responsive to any incoming PREA-related reports, although no reports were identified during the audit period. Third-Party Reporting System Functionality:

	As part of the review, the auditor evaluated the facility's third-party reporting system using the same method available to the general public (e.g., submission via the facility's official website). The auditor confirmed that the system was operational, the instructions were clear, and the method was appropriately designated for the reporting of sexual abuse and sexual harassment incidents. Verification of Report Receipt and Response Process: The auditor requested and received documentation confirming receipt of the test report submitted through the third-party system. This confirmed that reports made through external channels are received and processed in a timely and appropriate manner. Stakeholder Feedback: Informal conversations were held with staff, residents, and external reporting entities to gather feedback on the visibility, clarity, and functionality of facility signage and reporting options. The responses indicated a general understanding and awareness of reporting procedures and access to relevant information. Conclusion: The facility has implemented a signage and third-party reporting system that meets PREA requirements for clarity, accessibility, functionality, and responsiveness. Continuous monitoring and routine checks of signage and external reporting systems contribute to a transparent and trauma-informed environment that prioritizes resident safety and accountability. Interviews PREA Coordinator – The interviewed staff reported that if a client wishes to report abuse or harassment to an entity outside of the agency, they can contact the Sexual Assault Hotline, tell staff, or the police department. The agency provides clients with the Sexual Assault Hotline number at orientation, as well as information about their options for making such reports. The number is also posted in English and Spanish at the facilities. The procedures enable receipt and immediate transmission of resident reports of sexual abuse and sexual harassment to the agency, while the resident may choose to remain anonymous upon request. The crisis centers will forward reports of sexual abuse and sexual harassment to agency officials. Staff will accept anonymous and third-party reports, in addition to verbal or written reports. Resident Interview Questionnaire - The interviewed residents reported that they are aware of multiple methods to report sexual abuse or sexual harassment. They felt comfortable reporting incidents to staff and noted additional options, including calling PREA Hotline, filing written note to staff, texting staff, calling the program director, notifying PREA Coordinator Katie, notifying their probation officer, or asking a family member to report on their behalf. The interviewed residents knew how to report anonymously, such as writing a note, filing a grievance, calling a hotline, or texting the program director. Corrective Actions:

	N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.251 (c). Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports within 24 hours. · Policy: Reporting of Sexual Abuse or Harassment states that “Clients / Residents may make verbal or written reports of sexual abuse or harassment to their Clinician, Program Director, PREA Coordinator, Director of Quality Improvement or any other employee they feel comfortable in reporting sexual abuse or sexual harassment; Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and, staff neglect or violation of responsibilities that may have contributed to such incidents. • Staff must allow the client / resident a private area to report their concerns and make their report. Staff must accept both verbal and/or written incident reports. If the client / resident is willing to make a written report, the PREA incident report form should be utilized. If not, the staff person taking the report can write the report” (p. 1). · PREA Brochure: The PREA Brochure (115.333), provides residents with multiple ways to make a report. Interviews Random Sample of Staff – Staff confirmed that resident can report concerns regarding sexual abuse or sexual harassment verbally or in writing. All twelve staff interviewed stated they would immediately notify a supervisor upon receiving a report and follow proper procedures to ensure the allegation is addressed promptly. Resident Interview Questionnaire – Nine out of ten residents interviewed were aware that they can make a report of sexual abuse or sexual harassment either in person or in writing. Residents reported they can tell staff, write a grievance, tell counselor or family member to make the report on their behalf. One resident out of the ten interviewed was not aware that a third person could make a report on their behalf. Corrective Actions: N/A. There are no corrective actions for this provision.

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

115.251 (d). The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents.

Compliance Determination:

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

· Policy: Reporting of Sexual Abuse or Harassment states that “Staff shall report to their next level Supervisor and the agency’s PREA Coordinator any knowledge or suspicion of sexual abuse and/or harassment against a client / resident by another client/resident, employee, volunteer, intern, or contractor. Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents should also be reported. • Staff shall utilize the PREA Incident report form on behalf of the client / resident to initiate a response by the PREA Coordinator. • Staff may make such reports in a private manner of which they are comfortable. Such reports of sexual abuse, harassment, known retaliation, or concerns of neglect on the part of another staff, volunteer, intern, or contractor may be submitted in writing or verbally to the PREA Coordinator and may be done so anonymously” (p. 1).

Site Review:

Evaluation of Staff Reporting Methods:

As part of the audit process, the auditor initiated a review of the facility’s staff reporting methods by engaging a staff member to demonstrate the procedures in place for reporting incidents. This demonstration provided insight into the accessibility and functionality of the reporting methods available to staff.

Availability of Reporting Methods:
The auditor observed the availability of the staff reporting methods to ensure they are accessible to all staff throughout the facility. It was confirmed that the reporting system is readily available to staff members upon request. Staff members reported that they typically make reports directly to the director, and the director’s office is situated in a location away from resident areas, which facilitates confidential conversations.

Reporting Structure and Mandates:
The auditor assessed whether staff are required to report incidents to their immediate colleagues or supervisors. While it is the preferred method to report incidents to their immediate supervisor, staff members were able to articulate alternative reporting options, indicating flexibility in the facility’s reporting process.

Conclusion:
The facility’s staff reporting methods are accessible and functional, ensuring that

	staff members can report incidents confidentially and through multiple channels, including reporting to the director or immediate supervisor as appropriate. Interviews Random Sample of Staff – The interviewed staff reported that they could privately report sexual abuse and sexual harassment of residents by calling the PREA hotline, notify supervisor, HR, or email the PREA Coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.252	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act Resident Handbook Grievances Grievance Form Findings (By Provision): 115.252 (a). An agency shall be exempt from this standard if it does not have

	administrative procedures to address resident grievances regarding sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. · While the agency does not currently employ the grievance process to address allegations, it was determined that individuals have the option to utilize the grievance form to file a complaint. Upon filing, the complaint is promptly forwarded to the investigation process. During the onsite assessment, the auditor thoroughly examined the grievance logbook and found no instances of PREA-related grievances. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.252 (b). (1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. (2) The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse. (3) The agency shall not require a resident to use any informal grievance process, or to attempt to resolve with staff, an alleged incident of sexual abuse. (4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.252 (c). The agency shall ensure that: (1) A resident who alleges sexual abuse

may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint.

Compliance Determination:

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

· As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse.

Corrective Actions:

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

115.252 (d). (1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance. (2) Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal. (3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made. (4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.

Compliance Determination:

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

· As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse.

Corrective Actions:

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

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

115.252 (e). (1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. (2) If a third party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf and may also require the alleged victim to

personally pursue any subsequent steps in the administrative remedy process. (3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.

Compliance Determination:

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

· As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse.

Corrective Actions:

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

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

115.252 (f). (1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision documents the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

Compliance Determination:

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

· As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse.

Corrective Actions:

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

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

115.252 (g). The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.253	**Resident access to outside confidential support services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reporting of Sexual Abuse and/or Harassment (Review Date: 2025) MOU: Safe Haven of Greater Waterbury (2016/2020) Safe Haven of Greater Waterbury Sexual Assault Services Safe Haven Information Sheet PREA Brochure (English/Spanish) Carelogic Client PREA Brochure Acknowledgement (26)

	Email Correspondence with Safe Haven of Greater Waterbury Connecticut Alliance to End Sexual Violence Corrective Action Staff Training Resident Education Handbook Update Interviews: Resident Interview Questionnaire – (10) Findings (By Provision): 115.253 (a). The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse. The facility provides residents with access to such services by giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations. The facility provides residents with access to such services by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. · Policy: Reporting of Sexual Abuse and/or Harassment states that “Connecticut Renaissance will provide victims with access to external victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and phone numbers of such community resources. The programs shall enable communication between residents and such community resources in as confidential manner as possible” (p. 2). · Carelogic Client PREA Brochure Acknowledgement (26) · PREA Brochure (English/Spanish): provided to residents at intake states “Victims of sexual harassment and/or sexual abuse are offered advocacy services through Safe Haven, 29 Central Ave, Waterbury, CT. at (203) 753-3613 (hotline) or

at The Center for Family Justice in Bridgeport, CT at (203) 333-2233 (hotline)".

· MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services.

· Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education).

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

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

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

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

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

Site Review:

Assessment of Facility Signage and Third-Party Reporting Mechanisms:

During the onsite audit, the auditor conducted a comprehensive review of facility signage and third-party reporting systems to evaluate compliance with PREA

	standards and ensure that critical sexual safety information was accessible, accurate, and effectively communicated to staff, residents, and external parties. Signage Readability and Accessibility: The auditor carefully evaluated facility signage for clarity, readability, and accessibility. Signage language was reviewed to ensure it was written at an appropriate reading level—determined to be at or near the 5th grade level—and that it clearly communicated essential information related to PREA, including access to emotional support services and external reporting mechanisms. Multilingual Access: Signage was observed to be available in both English and the most commonly spoken languages within the facility population, effectively supporting residents with limited English proficiency. Design and Placement: Particular attention was paid to the font size, layout, and physical placement of signage. The auditor confirmed that signage was positioned to be easily visible and accessible to individuals of varying heights and abilities, including those with visual impairments or physical disabilities. Placement was confirmed throughout resident living areas, common spaces, staff-only zones, and areas accessible to the public. Accuracy and Consistency: Facility signage was reviewed for accuracy and consistency. Audit-related postings were up to date, and contact information for external agencies, such as the Department of Corrections and the Connecticut State Police, was verified. The auditor was able to confirm that both entities were accessible and responsive to any incoming PREA-related reports, although no reports were identified during the audit period. Third-Party Reporting System Functionality: As part of the review, the auditor evaluated the facility's third-party reporting system using the same method available to the general public (e.g., submission via the facility's official website). The auditor confirmed that the system was operational, the instructions were clear, and the method was appropriately designated for the reporting of sexual abuse and sexual harassment incidents. Verification of Report Receipt and Response Process: The auditor requested and received documentation confirming receipt of the test report submitted through the third-party system. This confirmed that reports made through external channels are received and processed in a timely and appropriate manner. Stakeholder Feedback: Informal conversations were held with staff, residents, and external reporting entities to gather feedback on the visibility, clarity, and functionality of facility signage and reporting options. The responses indicated a general understanding and awareness of reporting procedures and access to relevant information.

	TESTING ACCESS TO OUTSIDE EMOTIONAL SUPPORT SERVICES During the site review, the auditor must evaluate access to outside emotional support services or ask a person confined in the facility to evaluate access to outside emotional support services. Outside Emotional Support via Phone Assessment of Access to Outside Emotional Support Services via Phone: As part of the audit process, the auditor assessed the facility's compliance with providing residents direct access to call outside emotional support service providers. This evaluation involved several key steps to ensure that residents have the necessary resources to contact these services confidentially and with privacy. Phone Access and Functionality: The auditor conducted a test call to the designated outside emotional support service provider(s) using the same phone system available to residents. The test confirmed that the facility's phones were functional, providing a dial tone and the ability to connect calls outside the facility. Residents have access to their own phones and there are community phones available in the facility. Verification of Contact Information: The auditor verified that the phone number listed on signage throughout the facility correctly connects to the organization providing emotional support services. Additionally, the phone number was confirmed to be a local or toll-free number, ensuring accessibility for residents. Response from Service Provider: The auditor assessed the responsiveness of the emotional support service provider by speaking with the individual who answered the test call. It was confirmed that the service provider answered promptly and provided clear information about the services available to individuals confined in the facility, ensuring that the provider is prepared to offer support to residents. Regular Access and Accommodations: The auditor confirmed that all residents have regular access to phones to contact outside emotional support services. This includes ensuring that reasonable accommodations are provided for residents with specific needs, such as those who are Deaf or hard-of-hearing, Blind or have low vision, cognitively or functionally disabled, or who have limited English proficiency. The facility has ensured that accommodations are available to support these individuals in accessing the services they need. Confidentiality and Privacy of Phone Access: The auditor evaluated how the facility ensures that residents have access to phones that allow for private and unmonitored communication with outside emotional support services. The facility provides residents with the ability to make confidential calls, ensuring privacy when reaching out to these providers.

	Informal Conversations with Staff and Residents: Informal discussions were held with both staff and residents to gather feedback regarding the accessibility of outside emotional support services via phone. Residents reported that they are able to access the phone system to call these services, and staff confirmed their awareness of the procedures in place to ensure privacy and reasonable accommodations for those with specific needs. Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom) Incoming/Outgoing Mail: During the site review, the auditor observed the process for residents' access to and handling of incoming and outgoing mail, ensuring compliance with PREA standards. Access to Writing Materials: The auditor confirmed that residents have ready access to writing materials, including paper and pencils, to facilitate correspondence. Outgoing Mail Process: The process for outgoing mail was reviewed, and the following steps were observed: o Residents write their letters, place them in envelopes, and leave the mail in a designated area for collection. Staff daily retrieves the mail. o Staff verify that the resident is still at the facility before the mail is sent out. o Residents are required to open their mail in front of staff to ensure security. Staff reported that they do not read the contents of the mail. Access to Public Mail System: Residents also have the ability to send mail using the public mail system, ensuring they can correspond with external parties independently of the facility's internal processes. Interviews Resident Interview Questionnaire – Two of the ten interviewed residents reported that they were aware of outside services that deal with sexual abuse if needed. These two residents were unable to specifically provide names of services but knew would provide individual therapy or mental health services. The two residents interviewed were unable to name additional resources by name, however, mentioned that there is a list near nurse’s office and on the forms, they signed at intake with email addresses and phone numbers. Furthermore, the two residents interviewed stated they can contact services whenever a need arises. All residents can have access to landline phone and have access to their cell phones between 8-10pm every evening. Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process. Corrective Actions:

	Staff Training: Staff were not fully aware of what victim advocacy and emotional support services entailed. It is recommended that all staff include facility leadership and intake staff receive training and education on what victim advocacy and emotional support services entail. Ø Corrective Action Taken: Additional training was provided to staff. Resident Education: The residents are not fully aware of what victim advocacy and emotional support services entail. It is recommended that the residents receive additional information on victim advocacy and emotional support services. Ø Corrective Action Taken: Current Residents received additional information on victim advocacy and emotional support, additionally the agency added the information to the facility resident education. Resident Education/Intake: The agency shall develop a process to incorporate educating residents at intake on emotional support and victim advocacy services. This can be done by adding an additional handout our adding to the resident handbook and the staff overview the handbook. Ø Corrective action taken: the facility added information on victim advocacy and emotional support to the resident handbook. 115.253 (b). The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. · Policy: Reporting of Sexual Abuse and/or Harassment states that “Connecticut Renaissance will provide victims with access to external victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and phone numbers of such community resources. The programs shall enable communication between residents and such community resources in as confidential manner as possible” (p. 2). · PREA Brochure (English/Spanish): provided to residents at intake states “Victims of sexual harassment and/or sexual abuse are offered advocacy services

	through Safe Haven, 29 Central Ave, Waterbury, CT. at (203) 753-3613 (hotline) or at The Center for Family Justice in Bridgeport, CT at (203) 333-2233 (hotline)". · Residents at the facility have access to their own cell phones and a majority receive services (job/mental health) outside of the facility therefore have the ability to have confidential communication. Interviews Resident Interview Questionnaire – Two of the ten interviewed residents reported that they were aware of outside services that deal with sexual abuse if needed. The two residents interviewed stated that they are felt like any discussions about sexual abuse would remain private and confidential. They have access to their cell phones therefore they can make calls in the evening. Corrective Actions: Resident Handbook: The auditor recommends that the facility update the handbook to include details of what victim advocacy and emotional support entails and provide documentation to the auditor. Additionally, the handbook shall address any limitations to confidentiality. Ø Corrective action taken: the facility add information on victim advocacy and emotional support to the resident handbook. 115.253 (c). The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility maintains memorandum of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. · Policy: Reporting of Sexual Abuse and/or Harassment states that "The agency shall enter into memoranda of understanding or other agreements with community service providers that are able to provide clients/ residents with confidential, emotional support services related to sexual abuse. Connecticut Renaissance will maintain copies of such agreements or documentation showing attempts to enter into such agreements" (p. 2). · MOU: Safe Haven of Greater Waterbury provides crisis counseling and emotional support services.

	· Safe Haven Info Sheet provides a description of services offered (medical advocacy, legal advocacy, adult advocacy, child advocacy, child abuse intervention team, and community education). Corrective Actions: Safe Haven: While the facility has a contract with Safe Haven, the facility shall provide documentation showing that the contract is still valid, as the last contract was signed in 2016. The facility was able to provide additional documentation on the victim advocacy and emotional support services and an active relationship with the community partner. No further action is needed. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility shall address enhancements to the process of providing residents with access to victim advocacy and emotional support services in order to be compliant with the provisions of the standard. All corrective action measures were taken. The facility is compliant with all provisions of the standard.

115.254	**Third party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reporting of Sexual Abuse and/or Harassment Website: PREA | CT Renaissance PREA Brochure (English/Spanish) Prison Rape Elimination Act Client Sign Off Findings (By Provision): 115.254 (a). The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on

	how to report sexual abuse and sexual harassment on behalf of a resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The agency or facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. · Policy: Reporting of Sexual Abuse and/or Harassment states that “Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates shall be permitted to assist clients / residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. • If a third party files such a request on behalf of a resident, the facility may request, as a condition of processing the request that the alleged victim agree to have the request filed on his / her behalf. If the resident declines to have the request processed on his / her behalf, Connecticut Renaissance shall document such decision” (p. 2). · PREA Brochure (English/Spanish): provided to residents at intake provides various methods for reports of allegations of sexual abuse and sexual harassment. · Prison Rape Elimination Act Client Sign Off · Website PREA | CT Renaissance: Provides information to the public on third party reporting. Site Review: Assessment of Facility Signage and Third-Party Reporting Mechanisms: During the onsite audit, the auditor conducted a comprehensive review of facility signage and third-party reporting systems to evaluate compliance with PREA standards and ensure that critical sexual safety information was accessible, accurate, and effectively communicated to staff, residents, and external parties. Signage Readability and Accessibility: The auditor carefully evaluated facility signage for clarity, readability, and accessibility. Signage language was reviewed to ensure it was written at an appropriate reading level—determined to be at or near the 5th grade level—and that it clearly communicated essential information related to PREA, including access to emotional support services and external reporting mechanisms. Multilingual Access: Signage was observed to be available in both English and the most commonly spoken languages within the facility population, effectively supporting residents with limited English proficiency.

	Design and Placement: Particular attention was paid to the font size, layout, and physical placement of signage. The auditor confirmed that signage was positioned to be easily visible and accessible to individuals of varying heights and abilities, including those with visual impairments or physical disabilities. Placement was confirmed throughout resident living areas, common spaces, staff-only zones, and areas accessible to the public. Accuracy and Consistency: Facility signage was reviewed for accuracy and consistency. Audit-related postings were up to date, and contact information for external agencies, such as the Department of Corrections and the Connecticut State Police, was verified. The auditor was able to confirm that both entities were accessible and responsive to any incoming PREA-related reports, although no reports were identified during the audit period. Third-Party Reporting System Functionality: As part of the review, the auditor evaluated the facility's third-party reporting system using the same method available to the general public (e.g., submission via the facility's official website). The auditor confirmed that the system was operational, the instructions were clear, and the method was appropriately designated for the reporting of sexual abuse and sexual harassment incidents. Verification of Report Receipt and Response Process: The auditor requested and received documentation confirming receipt of the test report submitted through the third-party system. This confirmed that reports made through external channels are received and processed in a timely and appropriate manner. Stakeholder Feedback: Informal conversations were held with staff, residents, and external reporting entities to gather feedback on the visibility, clarity, and functionality of facility signage and reporting options. The responses indicated a general understanding and awareness of reporting procedures and access to relevant information. Conclusion: The facility has implemented a signage and third-party reporting system that meets PREA requirements for clarity, accessibility, functionality, and responsiveness. Continuous monitoring and routine checks of signage and external reporting systems contribute to a transparent and trauma-informed environment that prioritizes resident safety and accountability. Corrective Actions: N/A. There are no corrective actions for this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility,

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

115.261	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reporting of Sexual Abuse and/or Harassment Sample of Reports to Investigators (1) (uploaded in standard 115.286 (a)) Interviews: Random Sample of Staff (12) Director or Designee Medical and Mental Health Staff (2) PREA Coordinator Findings (By Provision): 115.261 (a). The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. The agency requires all staff to report

	immediately and according to agency policy retaliation against residents or staff who reported such an incident. The agency requires all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. · Policy: Reporting of Sexual Abuse and/or Harassment states that “Connecticut Renaissance requires all staff to report immediately and initiate a coordinated response to any knowledge, suspicion, or information regarding an incident of sexual abuse or harassment that may have taken place against a client by another client, employee, volunteer, intern, or contractor. Residents / Clients shall be encouraged and provided a safe means of reporting such abuse. Anyone who reports an allegation of sexual abuse or harassment may do so without fear of reprisal” (p. 1). The policy further states that “Staff shall report to their next level Supervisor and the agency’s PREA Coordinator any knowledge or suspicion of sexual abuse and/or harassment against a client / resident by another client/resident, employee, volunteer, intern, or contractor. Retaliation by other residents or staff for reporting sexual abuse or sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents should also be reported” (p. 1). Site Review: Evaluation of Staff Reporting Methods: During the site review, the auditor conducted a thorough assessment of the staff reporting methods utilized by the facility. This evaluation was aimed at ensuring that the reporting process is functional, accessible, and aligns with PREA standards. Observation of Reporting Process: A staff member was selected to walk the auditor through the facility's staff reporting procedures. This hands-on walkthrough provided the auditor with a firsthand understanding of the reporting process, allowing for a detailed evaluation of its accessibility and effectiveness. Availability of Reporting Methods: The auditor assessed the availability of the staff reporting system to ensure it can be accessed promptly by all staff members, as needed, throughout the facility. It was confirmed that the system is accessible to all staff at any time, ensuring they can report incidents without unnecessary delay. Reporting Structure and Hierarchy: In evaluating the reporting structure, the auditor explored whether staff were required to report incidents to their immediate supervisor or direct colleagues. While the primary expectation is for staff to report to their direct supervisor, staff members were able to articulate alternative reporting methods, indicating that the facility provides flexibility in the reporting structure to accommodate various circumstances. Conclusion:

	The facility's staff reporting methods are well-structured, accessible, and provide flexibility in reporting channels, ensuring that all staff can report incidents promptly and through multiple avenues as needed. Interviews Random Sample of Staff – Twelve staff interviewed indicated a clear understanding that the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurs in the facility. All twelve staff also reported that they understand they are prohibited from retaliating against resident or staff that reported sexual abuse or sexual harassment. The various ways staff indicated that they would report included, but was not limited to: · Report to supervisor · PREA Coordinator/ Hotline · Contact Police · File grievance Corrective Action: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.261 (b). Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, apart from reporting to designated supervisors or officials and designated state or local services agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. · Policy: The Reporting of Sexual Abuse and/or Harassment states that "Staff may make such reports in a private manner of which they are comfortable. Such reports of sexual abuse, harassment, known retaliation, or concerns of neglect on the part of another staff, volunteer, intern, or contractor may be submitted in writing or verbally to the PREA Coordinator and may be done so anonymously. •

	Apart from reporting to designated supervisors or the PREA Coordinator staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, review and other security and management decisions. • Unless otherwise precluded by Federal, State, or local law, agency staff shall be required to report sexual abuse and must inform client / residents of their duty to report, and the limitations of confidentiality at the initiation of services." (p. 1). · Investigation Report (1) Site Review: Assessment of Information and Documentation Storage Practices: During the site review, the auditor conducted a thorough assessment of the facility's information and documentation storage practices to ensure compliance with PREA standards regarding the confidentiality and security of sensitive information. Physical Storage of Documentation: The auditor observed the storage of client information, which was securely stored in the locked office of the assigned case manager. This ensured that sensitive data, including but not limited to risk screening information, medical records, and sexual abuse allegations, was kept in a secure, restricted area. Security of Physical Storage Areas: The physical storage areas were evaluated to determine the level of security in place. The auditor specifically looked for mechanisms, such as key access, to restrict unauthorized access to hard copy documentation. It was confirmed that access to these areas was appropriately controlled to maintain confidentiality. Electronic Information Safeguards: In addition to reviewing physical storage practices, the auditor also examined the facility's electronic safeguards for information stored electronically, including risk screening data. The auditor assessed the measures implemented to secure electronic access to sensitive information, ensuring that only authorized personnel had access to these records. Conclusion: The facility has implemented appropriate security measures for both physical and electronic storage of sensitive documentation. Access to these areas is restricted and well-controlled, in compliance with PREA standards to safeguard resident privacy and confidentiality. Interviews Random Sample of Staff – Twelve staff interviewed indicated a clear understanding that the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurs in the facility. All twelve staff also reported that they understand they are prohibited from retaliating against resident or staff that reported sexual abuse or sexual

harassment. The various ways staff indicated that they would report included, but was not limited to:

· Report to supervisor

· PREA Coordinator/ Hotline

· Contact Police

· File grievance

Corrective Actions:

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

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

115.261 (c). Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.

Compliance Determination:

· The medical and mental health staff are fully aware of their responsibilities to report.

Interviews:

Medical and Mental Health Staff – The interviewed staff reported that the clients are notified of the limitations of confidentiality during the intake process. All allegations would be reported to the director and the staff were not aware of any alleged incidents.

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

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

Compliance Determination:

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

· There are no residents under the age of 18.

	Interviews Director – The interviewed staff reported that while they do not have minors all allegations are investigated. PREA Coordinator - The interviewed staff reported that while we do not house clients who are 18 or under, if an allegation was made by an individual 18 or under or by someone considered a vulnerable adult, the facility would report to the PREA Coordinator, and the agency would follow the state mandated reporting laws. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.261 (e). The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Sample of reports to investigators (1). The reported allegation was reported by an agency staff member. Interviews Director or Designee: The interviewed staff reported that all allegations of sexual abuse and sexual harassment are received and reported. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.262	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Screening for Risk of Victimization and Abusiveness Policy: Reviewing and Responding to Allegations of Sexual Abuse and/or Sexual Harassment Interviews: Agency Head Director or Designee Random Sample of Staff (12) Findings (By Provision): 115.262 (a). When an agency learns that a resident is subject to substantial risk of imminent sexual abuse, it shall take immediate action to protect the residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay).In the past 12 months, the number of times the agency or facility determined that a resident was subject to a substantial risk of imminent sexual abuse: 0. If the agency or facility made such determinations in the past 12 months, the average amount of time (in hours) that passed before taking action: N/A. The longest amount of time (in hours or days) elapsed before taking action--if not "immediate" (i.e., without unreasonable delay). If not immediately, please explain in the comments section. N/A. · Policy: Screening for Risk of Victimization and Abusiveness states that “If the resident is identified from the screening as a vulnerable victim (VV) or as sexually aggressive (SA) these designations will be noted on the POP sheet to assist the staff in monitoring them” (p. 2). · Policy: Reviewing and Responding to Allegations of Sexual Abuse and/or Sexual

	Harassment states that “If the resident is identified from the screening as a vulnerable victim (VV) or as sexually aggressive (SA) these designations will be noted on the POP sheet to assist the staff in monitoring them” (p. 2). Interviews Agency Head – The interviewed agency head reported that if they learn that a resident is subject to a substantial risk of imminent sexual abuse the agency shall take immediate action to protect the resident. The agency would do so by increasing monitoring of the person and cameras and possibly staying in a single room. Director or Designee – The interviewed staff reported that when they learn that a resident is subject to a substantial risk of imminent sexual abuse the agency shall take immediate action. For example, separate them, investigate and/or have closer to staff. Random Sample of Staff – Twelve staff were interviewed. Two staff members stated that the program manager would conduct sexual abuse investigations, while nine stated that PREA Coordinator would manage sexual abuse investigations, and one indicated that police would conduct sexual abuse investigations. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.263	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations:

Pre-Audit Questionnaire (PAQ)

Policy: Reporting of Sexual Abuse and/or Harassment

Report to another confinement site

Interviews:

Agency head

Director or designee

Findings (By Provision):

115.263 (a). Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred.

Compliance Determination:

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

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

· Policy: The Reporting of Sexual Abuse and/or Harassment policy states that “Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Director that received the allegation shall notify the head of the facility or the appropriate office of the agency where the alleged abuse occurred” (p. 2).

Corrective Actions:

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

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

115.263 (b). Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.

Compliance Determination:

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

	· As reported the PAQ, the Agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. · Policy: The Reporting of Sexual Abuse and/or Harassment policy states that "Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Director that received the allegation shall notify the head of the facility or the appropriate office of the agency where the alleged abuse occurred" (p. 2). The policy further states that "Such notification must be done so as soon as possible, but no later than 72 hours after receiving the allegation" (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.263 (c). The agency shall document that it has provided such notification. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. · Policy: The Reporting of Sexual Abuse and/or Harassment policy states that "Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Director that received the allegation shall notify the head of the facility or the appropriate office of the agency where the alleged abuse occurred. • Such notification must be done so as soon as possible, but no later than 72 hours after receiving the allegation. • The Program Director will apprise the Connecticut Renaissance PREA Coordinator of such allegations and collaborate with the PREA Coordinator in terms of ensuring appropriate notifications. • The PREA Coordinator will maintain documentation of such reports and communication with other organizations" (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.263 (d). The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: 0. · Policy: The Reporting of Sexual Abuse and/or Harassment policy states that “If Connecticut Renaissance receives a report from another organization of an allegation of sexual abuse that supposedly occurred at a Connecticut Renaissance facility. Connecticut Renaissance shall follow up and initiate a review of the report” (p. 3). Interviews Agency head – The interviewed agency head reported that the PREA coordinator would be the point person for the investigation. All allegations would be investigated, and the executive team and HR would be updated on the results of the investigation. Director or designee – The interviewed staff reported that if the facility receives a report from another facility or agency that an incident of sexual abuse or sexual harassment occurred at the facility, the incident would be investigated and reported to the other entity. All allegations would go to the PREA Coordinator to be investigated. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.264	**Staff first responder duties**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reviewing and Responding to Allegations of Sexual Abuse Interviews: Security Staff and Non-Security Staff First Responders (10) Findings (By Provision): 115.264 (a). Upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to: (1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a first responder policy for allegations of sexual abuse. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to separate the alleged victim and abuser. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. The policy requires that, upon learning of an allegation that a resident was sexually abused and the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report shall be required to request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The policy requires that, upon learning of an allegation that a resident was sexually abused

	and the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report shall be required to ensure that the alleged abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. · In the past 12 months, the number of allegations that a resident was sexually abused: 0 · Of these allegations, the number of times the first security staff member to respond to the report separated the alleged victim and abuser: 0 · In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: N/A · Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report preserved and protected any crime scene until appropriate steps could be taken to collect any evidence: N/A · Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report requested that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating: N/A · Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report ensured that the alleged abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating: N/A · Policy: Reviewing and Responding to Allegations of Sexual Abuse, serves as the agency’s first responder policy. The policy provides a detailed description of the procedures for staff first responder duties. Interviews Security Staff and Non-Security Staff First Responders – All of the interviewed staff are considered first responders. The staff was able to articulate the first responder duties, such as securing the scene, getting the parties involved to a safe location, notifying their supervisor immediately or law enforcement, and ensuring that no one contained evidence. The staff struggled to articulate how to manage the evidence. Residents who Reported a Sexual Abuse – There were no residents who reported sexual abuse during the onsite audit.

	Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.264 (b). If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not to take any actions that could destroy physical evidence and then notify security staff. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence. As reported by the agency all staff are considered first responders. · Of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: N/A. · Of those allegations responded to first by a non-security staff member, the number of times that staff member requested that the alleged victim not take any actions that could destroy physical evidence: N/A. · Of those allegations responded to first by a non-security staff member, the number of times that staff member notified security staff: N/A. · Policy: Reviewing and Responding to Allegations of Sexual Abuse, serves as the agency's first responder policy. The policy provides a detailed description of the procedures for staff first responder duties. · Policy: Reviewing and Responding to Allegations of Sexual Abuse, indicates that all staff are considered first responders. Interviews Security Staff and Non-Security Staff First Responders/Random Sample of Staff – The interviewed staff reported that if they are the first person to be alerted that a resident has allegedly been the victim of sexual abuse, their responsibility is to immediately inform their supervisor, PREA Coordinator Katie and wait for further instructions. They also stated that they would not share the information with other residents or staff members who were not directly involved in managing the incident. Two out of twelve staff members indicated that they would relocate the resident to a single room.

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

115.265	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) West Coordinated Response Interviews: Director Findings (By Provision): 115.265 (a). The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first

	responders, medical and mental health practitioners, investigators, and facility leadership. · West Coordinated Response is a detailed plan providing an opportunity for staff to document any coordinated actions take to respond to an incident of sexual abuse among staff members, first responders, medical and mental health practitioners, investigators, and facility leadership. Interviews Director or Designee – The interviewed staff reported that the facility shall develop a written institution plan. This plan is currently being completed. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.266	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Interviews: Agency Head Findings (By Provision): 115.266 (a). Neither the agency nor any other governmental entity responsible for

	collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency, facility, or any other governmental entity is not responsible for collective bargaining on the agency's behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. Interviews Agency Head – The interviewed agency head reported that the agency has not entered into any collective bargaining agreements. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.266 (b). Nothing in this standard shall restrict the entering into or renewal of agreements that govern: (1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §115.272 and 115.276; or (2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A- Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.267	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act (PREA) Policy Interviews: Agency Head Director or Designee Designated Staff Member Charged with Monitoring Retaliation (or Director if nonavailable) - 1 Findings (By Provision): 115.267 (a). The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency designates staff member(s) or charges department(s) with monitoring for possible retaliation. · Policy: The Prison Rape Elimination Act (PREA) policy provides guidance on the protection of staff and residents who report sexual abuse. More specifically it states that “Any employee, contractor, intern, volunteer, or individual in the custody of the Judicial Branch or Department of Correction who reports an incident of sexual abuse or sexual harassment or cooperates in a sexual abuse or sexual harassment investigation must not be retaliated against. Any complaint of retaliation by an employee, contractor, intern, volunteer, or individual in the custody of the Judicial Branch or Department of Correction will be reported and investigated in accordance with the procedures and instruction provided in this policy. Any individual who is

found to have been in violation of this policy will be subject to appropriate disciplinary action and/or referred to the State Police for criminal investigation. • Connecticut Renaissance will take necessary measures to ensure protection of those reporting or assisting in the investigation of sexual abuse or sexual harassment. Such measures may include changing of residential assignment or staff assignment or offering emotional support services. • The agency's PREA Coordinator and Human Resources Department will monitor the conduct and treatment of those employees and individuals in the custody of the Judicial Branch or Department of Correction and will remedy any discovered retaliation" (p. 6).

Corrective Actions:

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

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

115.267 (b). The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

Compliance Determination:

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

· As reported in the PAQ, the agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

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

	or offering emotional support services. • The agency's PREA Coordinator and Human Resources Department will monitor the conduct and treatment of those employees and individuals in the custody of the Judicial Branch or Department of Correction and will remedy any discovered retaliation" (p. 6). Interviews Agency Head – The interviewed agency head reported that they would take protective measures of retaliation is identified. Such measures may include increased monitoring, possibly place in a single room, and increased camera monitoring. Director/Designee/Designated Staff Member Charged with Monitor Retaliation – The interviewed staff reported they generally monitor for retaliation with both clients and staff. When assessing clients, I will look at a loss of privileges and changes in treatment. For example, visitation being taken away, reduction in breaks, and changes to treatment services. When involving staff, I will look for threats and intimidation, changes to work hours and duties and working hours, along with performance appraisals. I will make contact with the residents directly. Residents who Reported a Sexual Abuse – there were no identified residents who reported a sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.267 (c). For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency/facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The

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

· Policy: The Prison Rape Elimination Act (PREA) Policy states that “For at least 90 days following a report of sexual abuse, Connecticut Renaissance shall monitor the conduct and treatment of clients / residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Monitoring shall continue beyond 90 days if initial monitoring indicates a continued need. Efforts to fulfill monitoring obligations will be documented and controlled by the PREA Coordinator” (p. 7).

Interviews

Director/Designee/ Designated Staff Member Charged with Monitoring Retaliation – The interviewed staff reported that if retaliation is suspected they would gather all of the facts via documentation along with reporting to the chain of command. As previously stated, shall monitor conduct and treatment of staff or residents. Monitoring would occur for at least 90 days. Items the agency will monitor include disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. Monitoring should occur for 90 days and beyond if needed.

Corrective Actions:

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

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

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

Compliance Determination:

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

There were no identified allegations if sexual abuse.

Interviews

Designated Staff Member Charged with Monitoring Retaliation (or Director if nonavailable) - The interviewed staff reported that they will monitor for changes in behavior. Additionally, the director provided a list of various ways in which they would monitor for retaliation. We will document the monitoring and refer to the PREA Coordinator. Some of the measures employed include housing changes, removal of alleged staff or resident abusers from contact with victims, and emotional support for residents or staff who fear retaliation for reporting sexual

	abuse or sexual harassment. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.267 (e). If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · There were no identified allegations of sexual abuse. Interviews Agency Head – The interviewed agency head reported that they would take protective measures of retaliation is identified. Such measures may include increased monitoring, possibly place in a single room, and increased camera monitoring. Director or Designee – The interviewed staff reported that they would monitor for changes in behavior, gather all of the facts and report the information through the chain of command. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.267 (f). An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A the auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility

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

115.271	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act (PREA) Policy Investigation (1) Interviews: PREA Coordinator Investigative Staff Director Findings (By Provision): 115.271 (a). When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency/facility has a policy related to criminal and administrative agency investigations. · Policy: The Prison Rape Elimination Act (PREA) Policy states that “All internal administrative investigations of allegations of sexual harassment will be conducted promptly, thoroughly, and objectively. The PREA Coordinator shall initiate and coordinate the investigation process. The Human Resources Department shall serve as the reviewing authority for all allegations of, sexual harassment, or retaliation involving a Connecticut Renaissance employee and an individual in the custody of

	the Judicial Branch or Department of Correction.” (pp. 5-6). · Investigation: There was one allegation investigated under PREA however the allegation was related to a resident having a crush on a staff member. The allegation was unsubstantiated. · All criminal matters will be referred to and investigated by CT State Police. Interviews Investigative Staff – The interviewed staff stated that Investigations are initiated immediately upon report of an allegation of sexual abuse or sexual harassment and are conducted promptly. All investigations are managed by the same standards. Anonymous or third-party reports follow the same protocols. Responses to all reports include keeping the victim safe from retaliation and reporting on the progress of the investigation. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.271 (b). Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.234. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. · Training Certificate of Completion (PREA: Investigating Sexual Abuse in a Confinement Setting) and Training Certificate (Your Roles and Responsibilities) can be located in standard 115.234. Interviews Investigative Staff – The interviewed staff stated that they have completed the NIC specialized training. The National Institute of Corrections courses called PREA: Investigating Sexual Abuse in a Confinement Setting and PREA: Coordinators’ Roles and Responsibilities. Corrective Actions:

	N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.271 (c). Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · There were no identified or reported allegations of sexual abuse or sexual harassment to review that involved circumstantial evidence. Interviews Investigative Staff – The interviewed staff stated that when an allegation is made, first responders utilize the Coordinated Response Plan to determine immediate actions including separation of the victim and suspect, immediate first aid and preservation of evidence. Criminal investigations are conducted by the State Police who would be contacted by first responders as part of the coordinated response. Administrative investigations begin when the PREA Coordinator is notified. Once confirming that the investigation is Administrative in nature, the context and details of the allegation are clarified via formal and informal interviews, review of any evidence, and review of records that may have a bearing on the case. The PREA Coordinator initiates and coordinates the investigation process, which takes into account physical, testimonial and documentary evidence gathered from interviews, records, electronic equipment, and any relevant source. The internal administrative investigation will include whether the alleged incident of sexual harassment, or retaliation was the result of employee misconduct or negligence. The investigation is documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The Human Resources Department serves as the reviewing authority for all allegations of, sexual harassment, or retaliation involving a CT Renaissance employee, following the full HR investigative process. Also, as the PREA Coordinator, I am responsible for gathering testimonial and documentary evidence, which may include but is not limited to formal and informal interviews, documentation of physical evidence, or electronic data and records that may be pertinent to the situation. Evidence collection in criminal investigations is managed by the State Police, while the agency’s coordinated response includes preservation of evidence.

	Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.271 (d). When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigative Report: There were no criminal-related allegations during the audit period. Interviews Investigative Staff – The interviewed staff reported that all information and referral for prosecution would be managed by outside law enforcement. CT Renaissance does not conduct criminal investigations. Upon report of any possible criminal conduct or prosecutable crime, State Police are immediately contacted. State Police would confer with prosecutors in the handling of allegations that appears to be criminals. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.271 (e). The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. Compliance Determination: he facility has demonstrated compliance with this provision of the standard because: · The auditor determined that residents are not required to take a polygraph test.

Interviews

Investigative Staff – The interviewed staff stated that credibility will not be assessed based on an individual's status as a client or staff person. Reasoning behind credibility assessments is documented as part of the written investigative report. A resident who alleges sexual abuse will never be required to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation.

Residents who Reported Sexual Abuse – There were no reported residents at the site during the onsite audit who had reported sexual abuse.

Corrective Actions:

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

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

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

Compliance Determination:

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

· Policy: The Prison Rape Elimination Act (PREA) Policy states that "The internal administrative investigation will include whether the alleged incident of sexual harassment, or retaliation was the result of employee misconduct or negligence. • The investigation shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings." (p. 6).

· There was one allegation of sexual abuse whereas an administrative investigation was conducted.

Site Review:

RECORD STORAGE

Assessment of Information and Documentation Storage Practices:

During the site review, the auditor conducted a thorough assessment of the facility's information and documentation storage practices to ensure compliance with PREA standards regarding the confidentiality and security of sensitive information.

	Physical Storage of Documentation: The auditor observed the storage of client information, which was securely stored in the locked office of the assigned case manager. This ensured that sensitive data, including but not limited to risk screening information, medical records, and sexual abuse allegations, was kept in a secure, restricted area. Security of Physical Storage Areas: The physical storage areas were evaluated to determine the level of security in place. The auditor specifically looked for mechanisms, such as key access, to restrict unauthorized access to hard copy documentation. It was confirmed that access to these areas was appropriately controlled to maintain confidentiality. Electronic Information Safeguards: In addition to reviewing physical storage practices, the auditor also examined the facility's electronic safeguards for information stored electronically, including risk screening data. The auditor assessed the measures implemented to secure electronic access to sensitive information, ensuring that only authorized personnel had access to these records. Conclusion: The facility has implemented appropriate security measures for both physical and electronic storage of sensitive documentation. Access to these areas is restricted and well-controlled, in compliance with PREA standards to safeguard resident privacy and confidentiality. Interviews Investigative Staff – The interviewed staff reported that internal administrative investigation always includes whether the alleged incident of sexual harassment, or retaliation was the result of employee misconduct or negligence. The determination is based on the available evidence and is subject to a review process by which recommendations are made to prevent future instances of staff misconduct or negligence. The investigation shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.271 (g). Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. There were no reported criminal investigations. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · Investigative Report: there were no identified criminal investigations reports during the audit period. Interviews Investigative Staff – The interviewed staff reported that the State Police would maintain documentation of their criminal investigations. CT Renaissance would make every effort to remain in communication with the State Police and to obtain a copy of their final report. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.271 (h). Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, substantiated allegations of conduct that appear to be criminal are referred for prosecution. There were zero number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit. The number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012, or since the last PREA audit, whichever is later: 0. · There were no reported criminal investigations. Interviews Investigative Staff – The interviewed staff reported that outside law enforcement would address referrals for prosecution. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.271 (i). The agency shall retain all written reports referenced in paragraphs (f)

	and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual assault or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. · Policy: The Prison Rape Elimination Act states that “The agency shall retain all written reports referenced in this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years” (p. 6). Interviews Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.271 (j). The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Investigative Staff – The interviewed staff reported that Investigations continue through final determination and review regardless of a staff member’s employment status. The employment status has no bearing on the status of the investigation. The investigation process does not change based on whether the victim or alleged abuser has left the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

	115.271 (k). Auditor is not required to audit this provision. 115.271 (l). When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Director – The interviewed staff reported that the PREA Coordinator would maintain contact with law enforcement to ascertain information on the case. PREA Coordinator – The interviewed staff reported that PREA Coordinator and Facility Director proactively communicate with any outside agency investigation into allegations of sexual abuse. Criminal investigations are managed by the State Police, with whom the agency remains in contact until receipt of a final report. Investigative Staff – The interviewed staff reported that the Facility Director and PREA Coordinator make every effort to remain in communication with the outside agency to get information on the progress of the investigation. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Following analysis, upon review of additional information the facility is compliant with the standard.

115.272	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination:

	Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Prison Rape Elimination Act (PREA) Policy Investigation Report (uploaded in 115.286) Interviews: Investigative Staff Findings (By Provision): 115.272 (a). The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency does not impose a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse of sexual harassment are substantiated. · There was one reported allegation of sexual harassment whereas a resident was crushing on a staff member. The allegation was investigated under PREA and was unsubstantiated. · Policy: Prison Rape Elimination Act provides guidance on the administrative investigation process and the standards imposed. “The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual harassment are substantiated.” (p. 6). Interviews Investigative Staff – The interviewed staff reported that the agency will impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual harassment are substantiated. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility

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

115.273	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reviewing and Responding to Allegations of Sexual Abuse Interviews: Director Investigative Saff Findings (By Provision): 115.273 (a). Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a policy requiring that any resident who alleges that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility in the past 12 months: 0. Of the alleged sexual abuse investigations that were completed in the past 12 months, the number of residents who were notified, verbally or in writing, of the results of the investigation: 0. · Policy: The Prison Rape Elimination Act states that “Following a review into a client/resident’s allegation of sexual abuse suffered while receiving services in a CT Renaissance facility, the PREA Coordinator shall inform the client / resident as to

	whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded." (p. 2). Interviews Director or Designee – The interviewed staff reported that the facility notifies a resident who makes an allegation of sexual abuse when the allegation has been determined substantiated, unsubstantiated, or unfounded following an investigation. Investigative Staff – The interviewed staff reported that following a review into a client / resident's allegation of sexual abuse in a CT Renaissance facility, the PREA Coordinator informs the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. This notification is to be documented. Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.273 (b). If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, if an outside entity conducts the investigation, the agency will request the relevant information from the investigation entity in order to inform the resident of the outcome of the investigation. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months: 0. Of the outside agency investigations of alleged sexual abuse that were completed in the past 12 months, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigation: N/A no investigations by the outside agency. There were no identified reports where an outside entity conducted an investigation on the site. Corrective Actions: N/A. There are no corrective actions for this provision.

	Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.273 (c). Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever: (1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Compliance Determination: · The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, following a resident’s allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless unfounded) whenever: o The staff member is no longer posted within the residents’ unit; o The staff member is no longer employed at the facility; o The agency learns that the staff member has been indicated on a charge related to sexual abuse within the facility; or o The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. · Policy: Reviewing and Responding to Allegations of Sexual abuse. states that “following a review into a client/resident’s allegation of sexual abuse suffered while receiving services in a CT Renaissance facility, the PREA Coordinator shall inform the client / resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The client shall be informed (unless the alleged sexual abuse was determined to be unfounded) whenever: The staff member is no longer assigned within the residents unit; The staff member is no longer employed at the facility; CT Renaissance learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility” (p. 2). There were no identified allegations of sexual abuse. Interviews Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process.

	Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.273 (d). Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: 1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or 2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. All such notifications or attempted notifications shall be documented. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the following a resident’s allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whomever the agency learns that the alleged abuser has been indicated on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. · Policy: Reviewing and Responding to Sexual Abuse states that “Following a clients allegation that he/she has been sexually abused by another resident, CT Renaissance shall subsequently inform the alleged victim whenever: CT Renaissance learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility” (2). There were zero allegations of sexual abuse reported at the facility in the last 12 months. Interviews Residents who Reported a Sexual Abuse – There were no resident who reported sexual abuse during the audit period nor onsite during the audit process. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.273 (e). All such notifications or attempted notifications shall be documented.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a policy that all notifications to residents described under this standard are documented. In the past 12 months, the number of notifications to residents that were provided pursuant to this standard: 0. Of those notifications made in the past 12 months, the number that were documented: 0. · Policy: Reviewing and Responding to Sexual Abuse states that “All notifications or attempted notification shall be documented and maintained in a file by the PREA Coordinator.” (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.273 (f). The auditor is not required to audit this provision of the standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.276	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reviewing and Responding to Allegations of Sexual Abuse

	Findings (By Provision): 115.276 (a). Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. · Compliance Determination: · Policy: Reviewing and Responding to Allegations of Sexual Abuse · states that “Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies” (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.276 (b). Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. The facility has demonstrated compliance with this provision of the standard because: Compliance Determination: · As reported in the PAQ, the disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. In the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies: 0. In the past 12 months, the number of staff from the facility who have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: 0. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that “Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse” (p. 2). Corrective Actions:

	N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted. 115.276 (c). The disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, In the past 12 months, the number of staff from the facility who have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse): 0 · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that "Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall commensurate with the nature and circumstances of the acts committed, the staff member' disciplinary history and the sanctions imposed for comparable offenses by other staff with similar histories" (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.276 (d). All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ, all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies. In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: 0. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that "All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies" (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.277	**Corrective action for contractors and volunteers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reviewing and Responding to Allegations of Sexual Abuse Interviews: Director

	Findings (By Provision): 115.277 (a). Any contractor or volunteer who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. · In the past 12 months, contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents: 0. · In the past 12 months, the number of contractors or volunteers reported to law enforcement for engaging in sexual abuse of residents: 0. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that “Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies” (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.277 (b). The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

	· Policy: Reviewing and Responding to Allegations of Sexual Abuse states that "The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer." Interviews Director or Designee – The interviewed staff reported that if any volunteer or contractor was found guilty of sexual abuse or sexual harassment, the situation would be assessed with the PREA Coordinator and determination would be made to allow the person back into the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.278	**Disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Reviewing and Responding to Allegations of Sexual Abuse Interviews: Director Medical and Mental Health Staff 92) Findings (By Provision):

	115.278 (a). Residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. · In the past 12 months, the number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: 0. · In the past 12 months, the number of criminal findings guilty of resident-on-resident sexual abuse has occurred at the facility: 0. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that “Clients / Residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guild for resident-on resident sexual abuse” (p. 3). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.278 (b). Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · There were no reported allegations that required sanctions to review. Interviews Director or Designee – The interviewed staff reported that residents shall be subject to disciplinary action pursuant to a formal disciplinary process following an

	administrative finding that the resident engaged in sexual abuse or following a criminal finding. Disciplinary action shall consider whether or not a resident's mental disability or illness contributed to the behavior. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.278 (c). The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · There were no reported allegations that required sanctions to review. Interviews Director or Designee – The interviewed staff reported that residents shall be subject to disciplinary action pursuant to a formal disciplinary process following an administrative finding that the resident engaged in sexual abuse or following a criminal finding. Disciplinary action shall consider whether or not a resident's mental disability or illness contributed to the behavior. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.278 (d). If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. · As reported in the PAQ, the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. Services are referred to a community partner. Interviews: Medical and Mental Health Staff – The interviewed staff reported that the facility

	provides mental health counseling services and will address any underling reasons or motivation for abuse. It was further reported that clients are not disciplined for refusing to participate in services. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.278 (e). The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. The facility has demonstrated compliance with this provision of the standard because: Compliance Determination: · As reported in the PAQ, the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that "CT Renaissance may impose disciplinary sanctions on a client / resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact" (p. 3). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.278 (f). For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation; Compliance Determination: · There were no reported allegations that required sanctions to review. The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish sufficient evidence to

	substantiate the allegation. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that "For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if a review does not establish evidence sufficient to substantiate the allegation" (p. 3). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.278 (g). An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency prohibits all sexual activity between residents and the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. · Policy: Reviewing and Responding to Allegations of Sexual Abuse states that "CT Renaissance prohibits all sexual activity between residents and will follow up with disciplinary action for such activity. CT Renaissance will not deem such activity to constitute sexual abuse if it is determined that the activity is not coerced." (p. 3). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.282	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Medical and Mental Health Care for Victims of Sexual Abuse (Review Date: 2025) Resident Handbook Interviews: Medical and Mental Health Staff (2) Security Staff and Non-Security Staff First Responders (7) Findings (By Provision): 115.282 (a). Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. · Policy: The Medical and Mental Health Care for Victims of Sexual Abuse policy states that “Victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment” (p. 1). · Resident Handbook: The resident handbook provides residents information on the site rules related to sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment; along with general information on access to medical and mental health services. Interviews

	Medical and Mental Health Staff-The interviewed staff reported that residents receive timely and unimpeded access to emergency medical treatment and crisis intervention services. This would occur as soon as the allegation is reported. The judgement of the treatment providers is taken into consideration. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.282 (b). If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to 115.262 and shall immediately notify the appropriate medical and mental health practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Policy: The Medical and Mental Health Care for Victims of Sexual Abuse policy states that “Upon receiving a report of alleged sexual abuse or sexual harassment, Connecticut Renaissance shall promptly connect the victim with emotional support services including a mental health evaluation and, as appropriate treatment planning, recommended treatment services and referrals for continued care following discharge” (p. 1). Interviews Security Staff and Non-Security Staff First Responders – All of the direct care staff are first responders. The staff interviewed were responsible for the agency’s first responder protocol, which included how to protect the evidence, separate the parties involved, and report to supervisor/ management for further action. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.282 (c). As reported in the PAQ, resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Interviews Security Staff and Non-Security Staff First Responders – All of the direct care staff are first responders. The staff interviewed were responsible of the agencies first responder protocol, which included how to protect the evidence, separate the parties involved, and report to supervisor/ management for further action. It should be noted that the staff struggled with answering how to properly protect evidence. Medical and Mental Health Staff – The interviewed staff reported that victims of sexual abuse would be offered access to emergency contraception and sexually transmitted infection prophylaxis. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.282 (d). Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. · Policy: The Medical and Mental Health Care for Victims of Sexual Abuse policy states that “Connecticut Renaissance shall offer all victims of sexual abuse access to forensic medical examinations without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If the area hospitals do not have available SAFE or SANEs then the examination can be performed by other qualified medical practitioners” (p. 1).

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

115.283	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: The Medical and Mental Health Care for Victims of Sexual Abuse Interviews: Medical and Mental Health Staff (2) Findings (By Provision): 115.283 (a). The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility does offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized

by sexual abuse in any prison, jail, lockup, or juvenile facility.

· Policy: The Medical and Mental Health Care for Victims of Sexual Abuse policy states that “Upon receiving a report of alleged sexual abuse or sexual harassment, Connecticut Renaissance shall promptly connect the victim with emotional support services including a mental health evaluation and, as appropriate treatment planning, recommended treatment services and referrals for continued care following discharge. • Connecticut Renaissance shall offer all victims of sexual abuse access to forensic medical examinations without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If the area hospitals do not have available SAFE or SANEs then the examination can be performed by other qualified medical practitioners” (p. 1).

Corrective Actions:

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

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

115.283 (b). The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

Compliance Determination:

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

There were no identified victims of sexual abuse to review information.

Interviews

· Medical and Mental Health Staff – The interviewed staff reported that if there is a victim of sexual abuse, the facility would offer medical care and individual one on one counseling services. The facility would also reach out to Safe Haven advocacy center for additional supportive services.

Residents who Reported a Sexual Abuse – there were no identified residents who reported a sexual abuse during the onsite audit period.

115.283 (c). The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard

	because: · There were no identified victims of sexual abuse to review information. Interviews: Medical and Mental Health Staff – The interviewed staff reported that the facility services are consistent with the community level of care or higher than. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.283 (d). NA-the facility only houses male residents. 115.283 (e). NA-the facility only houses male residents 115.283 (f). Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. The agency does not provide treatment services onsite all services will be referred for offsite medical care. · Policy: The Medical and Mental Health Care for Victims of Sexual Abuse policy states that “The Agency does not provide specialized treatment services for victims of sexual assault; victims will be referred to outside source for medical and mental health services” (p. 1). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.283 (g). Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · There were no identified victims of sexual abuse to review information. Interviews: Residents of Sexual Abuse: There were no residents of sexual abuse at the facility during the onsite audit period. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.283 (h). The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Policy: The Medical and Mental Health Care for Victims of Sexual Abuse policy states that “A referral for treatment services shall be provided to the victim. • The Agency does not provide specialized treatment services for victims of sexual assault; victims will be referred to outside source for medical and mental health services” (p. 1). Interviews: Medical and Mental Health Staff – The interviewed staff reported that they will conduct a mental health evaluation on all known resident on resident abusers within 60 days of learning of such abuse history. Typically, this would be done immediately. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and

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

115.286	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Data Collection and Review of Sexual Abuse Incidents (Review Date: 2025) PREA Incident Report/Investigation (1) PREA Annual Report (2024) Interviews: Director PREA Coordinator Incident Review Team (1) Findings (By Provision): 115.286 (a). The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only “unfounded” incidents: 0. · Policy: The Data Collection and Review of Sexual Abuse Incidents Policy states,

	“Connecticut Renaissance shall conduct a sexual abuse incident review at the conclusion of every sexual abuse report and administrative investigation of sexual harassment allegations, including where the allegation has not been substantiated, unless the allegation has been unfounded” (p. 1). · PREA Incident Review: The auditor reviewed one allegation of sexual harassment that an incident review was conducted. The incident review was a result of an unsubstantiated sexual harassment allegation. · Investigation: the investigation review was attached to the incident review. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.286 (b). Such review shall ordinarily occur within 30 days of the conclusion of the investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility were followed by a sexual abuse incident review within 30 days, excluding only “unfounded” incidents: 0. · Policy: The Data Collection and Review of Sexual Abuse Incidents Policy states, “The review shall occur within 30 days of the conclusion of the investigation.” (p. 1). · PREA Incident Review: The auditor reviewed one allegation of sexual harassment that an incident review was conducted. The incident review was a result of an unsubstantiated sexual harassment allegation. The incident review was conducted within 30 days of the results of the investigation. · Investigation: the investigation review was attached to the incident review. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard.

	115.286 (c). The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. · Policy: The Data Collection and Review of Sexual Abuse Incidents Policy states, “The review team shall include the Chief Operating Officer, PREA Coordinator, Program Director, Department Director and Direct Care staff and medical or mental health practitioners.” (p. 1). · PREA Incident Review: The auditor reviewed one allegation of sexual harassment that an incident review was conducted. The incident review was a result of an unsubstantiated sexual harassment allegation. The incident review involved upper-level management. Interviews Director or Designee – The interviewed staff reported that the incident review team consists of upper-level management. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.286 (d). The review team shall: (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA Coordinator.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1) -(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator. · Policy: The Data Collection and Review of Sexual Abuse Incidents Policy states "The review team shall: o Consider whether the allegation or administrative review indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; o Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; o Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; o Assess the adequacy of staffing levels in that area during different shifts; o Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; o Prepare a report of its findings, including but not necessarily limited to determinations made by the review team along with any recommendations for improvement. The report shall be submitted to the Chief Executive Officer, Board of Directors and PREA Coordinator. o Connecticut Renaissance shall implement recommendations for improvement or document reasons for not doing so." (p. 1). · PREA Incident Review: The auditor reviewed one allegation of sexual harassment that an incident review was conducted. The incident review was a result of an unsubstantiated sexual harassment allegation. The incident review documentation considered all of the above. Interviews Director – The interviewed staff reported that the incident review will be used to determine next steps. This may include training and what should happen with staff and or residents. PREA Coordinator – The interviewed staff reported that Sexual abuse incident reviews are overseen by the PREA Coordinator in collaboration with the Facility Director and staff. The review process specifically considers any needed changes, including: if there is a need to modify policy or practice, whether the incident/ allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; an assessment of the area in the facility where the incident allegedly occurred; adequacy of staffing levels in the area during different shifts; and whether monitoring technology should be deployed or augmented to supplement supervision

	by staff. The review and recommendations are documented. Incidents are then summarized in an annual report. Yes, if a facility conducts an incident review the report would be sent to me. No incidents were reported. The PREA Coordinator is involved both in the development of the report, and in ensuring that recommendations are implemented and followed, be it changes to facility, policy and procedure, education, or other areas. The agency's quality and safety processes also ensure that such changes are successfully implemented and maintained. Incident Review Team - Incident Review Team – The interviewed staff reported that Incident Reviews are completed and documented 30 days following an incident or alleged incident. During each incident review, the team considers when the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. During the investigation as well as during the review of the incident, the area in the facility where the incident allegedly occurred is assessed to determine whether any barriers in the facility could potentially enable abuse. Should this be true, steps would be taken to increase monitoring and/or eliminate the physical barriers. Staffing levels are always assessed during incident reviews. The technology monitoring at our facility is assessed during investigation and discussed during incident reviews. Our East site is equipped with video surveillance which has the ability to play back videos. We analyze the monitoring abilities/ needs and deploying or augmenting will occur should it be deemed necessary to supplement supervision by staff. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.286 (e). The facility shall implement the recommendations for improvement or shall document its reasons for not doing so. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility implements recommendations for improvement or documents and its reasons for not doing so. · PREA Incident Review (1) was provided, showing how the agency documents sexual abuse incident reviews. · The PREA Incident Review form documents incidents of sexual abuse or harassment involving individuals under the custody of the Judicial Branch or Department of Corrections. This form collects essential information to facilitate the

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

115.287	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Data Collection and Review of Sexual Abuse Incidents (Review Date: 2025) PREA SSV Report Findings (By Provision): 115.287 (a). The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. · Policy: The Data Collection and Review of Sexual Abuse Incidents Policy states that “Connecticut Renaissance shall collect accurate, uniform data for every allegation of sexual abuse at facilities. A set of standards shall be established to track occurrences and their circumstances” (p. 1). Corrective Actions: N/A. There are no corrective actions for this provision.

	Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.287 (b). The agency shall aggregate the incident-based sexual abuse data at least annually. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Annual Report (standard 115.286) provides aggregate data of the allegations of sexual abuse and sexual harassment. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.287 (C). The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. · Policy: The Data Collection and Review of Sexual Abuse Incidents Policy states that “The incident-based data collected shall include at a minimum the data necessary to answer all questions from the most recent version of the survey of Sexual Violence conducted by the Department of Justice” (p. 1). · SSV Report: the last SSV report was documented and reviewed. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.287 (d). The agency shall maintain, review, and collect data as needed from all

	available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. · Policy: The Data Collection and Review of Sexual Abuse Incidents Policy states that “Connecticut Renaissance shall maintain, review and collect data as needed from all available incident-based documents including reports, investigation files and sexual abuse incident reviews” (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.287 (e). The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. N/A the agency does not contract for the confinement of its residents. 115.287 (f). Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. N/A the DOJ has not requested agency data. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.288	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Data Collection and Review of Sexual Abuse Incidents (Review Date: 2025) Website https://ctrenaissance.org/about/licensing-accreditation/prea/ Annual Report (2023/2024) Interviews: Agency Head PREA Coordinator Findings (By Provision): 115.288 (a). The agency shall review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: (1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including: (a) identifying problem areas; (b) taking corrective action on an ongoing basis; and (c) preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. · Policy: The Data Collection and Review of Sexual Abuse Incidents policy states that “Connecticut Renaissance shall review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices, and training. Including; • Identifying problem areas; • Taking corrective action on an ongoing basis; • Preparing an annual report of its findings and corrective actions for each facility as well as the agency as a whole. Such report shall include a comparison of the current year’s data and corrective actions with those from prior years and shall provide an assessment of the agency’s progress in addressing sexual abuse” (p. 2). · The annual report can be located on the agency website at: https://ctrenaissance.org/about/licensing-accreditation/prea/

	· Any corrective action plans are addressed on the agency annual report. Interviews: Agency Head – The interviewed agency head reported that following the report of an allegation, an incident review is conducted to determine how the incident occurred and make steps to prevent the possibility of abuse or harassment happening. PREA Coordinator – The interviewed staff reported that the data and annual reports are reviewed by CT Renaissance leadership and made available through the agency website. The annual report outlines findings and corrective action for the facility as well as the agency. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.288 (b). Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the annual report includes a comparison of the current year’s data and corrective actions with those from prior years. The annual report provides an assessment of the agency’s progress in addressing sexual abuse. · Annual Report (2023/2024): the annual report was reviewed and found to have provided data and corrective actions for prior years. · The annual report can be located on the agency website at: https://ctrenaissance.org/about/licensing-accreditation/prea/ Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.288 (c). The agency's report shall be approved by the agency head and made readily available to the public through its Web site or, if it does not have one,

	through other means. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency makes its annual report readily available to the public at least through its website. The annual report is approved by the agency head. · Annual Report (2023/2024): the annual report was reviewed and found to have provided data and corrective actions for prior years. · The annual report can be located on the agency website at: https://ctrenaissance.org/about/licensing-accreditation/prea/ Interviews Agency Head – The interviewed agency head reported that they approve the annual reports. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.288. (d). The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. · Policy: The Data Collection and Review of Sexual Abuse Incidents policy states that “Data and associated annual reports shall be reviewed by Connecticut Renaissances’ Leadership and made available through the agency’s website. Connecticut Renaissance may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility. The nature of the material redacted would need to be indicated” (p. 2).

	· Annual Report: upon review of the annual report, there are no identifiers provided that could pose a threat to safety and security at the facility. Interviews: PREA Coordinator- The interviewed staff reported that prior to making the data available on the website, all personal identifiers are removed. CT Renaissance may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility. The nature of the material redacted would need to be indicated. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.289	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Supporting Documents, Interviews and Observations: Pre-Audit Questionnaire (PAQ) Policy: Data Collection and Review of Sexual Abuse Incidents (Review Date: 2025) Website: https://ctrenaissance.org/about/licensing-accreditation/prea/ Interviews: PREA Coordinator Findings (By Provision):

	115.289 (a). The agency shall ensure that data collected pursuant to § 115.287 are securely retained. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency ensures that incident-based and aggregate data are securely retained. The agency indicates the nature of material redacted. · Policy: The Data Collection and Review of Sexual Abuse Incidents policy states that “Data and associated reports on sexual abuse and sexual harassment shall be securely retained” (p. 2). Interviews PREA Coordinator – The interviewed staff reported that the PREA Coordinator issues an annual report with aggregated data for the agency and each facility in order to assess and improve the effectiveness of its sexual abuse response. The report includes comparisons of data across years, identification of problem areas, evaluation of corrective actions, and the overall quality of the agency’s sexual abuse response. Facility level data is included in the report. The report is reviewed by senior leadership. All critical data and documents are stored on a secure network server which is regularly backed up. CT Renaissance conducts internal quality reviews of incidents, data, and corrective action to ensure the health and safety of our clients and to prevent further incidents of sexual abuse or harassment. Data and annual reports are reviewed by CT Renaissance leadership and made available through the agency website. The annual report outlines findings and corrective action for the facility as well as the agency. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.289 (b). The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its Web site or, if it does not have one, through other means. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which its contracts be made readily available to the public at least annually.

	· Policy: The Data Collection and Review of Sexual Abuse Incidents policy states that “Connecticut Renaissance shall post annually all aggregated sexual abuse data from its programs readily available to the public through its website” (p. 2). · The annual report can be located on the agency website at: https://ctrenaissance.org/about/licensing-accreditation/prea/ Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.289 (c). Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. · Policy: The Data Collection and Review of Sexual Abuse Incidents policy states that “Prior to making data available, all personal identifiers shall be removed” (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. 115.289 (d). The agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection

	unless Federal, State, or local law requires otherwise. · Policy: The Data Collection and Review of Sexual Abuse Incidents policy states that “Connecticut Renaissance shall maintain sexual abuse data collected for at least 10 years after the date of the initial collection unless Federal, State or local law requires otherwise” (p. 2). Interviews: PREA Coordinator: Prior to making the data available on the website, all personal identifiers are removed. CT Renaissance may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility. The nature of the material redacted would need to be indicated. Corrective Actions: N/A. There are no corrective actions for this provision. Discussion: A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Findings (By Provision): 115.401 (a). The agency website contains the results of all the PREA audits conducted. 115.401 (b). The site is in Cycle 4 Audit Year 3. 115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the site by the program lead. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred

	or deterred entry to any areas. The auditor had the ability to freely observe, with entry provided to all areas without prohibition. Based on review of documentation the site is compliant with the intent of the provision. 115.401 (i). During the on-site visit, the auditor was provided access to all documents requested. All documents requested were received to include, but not limited to employee and resident files, sensitive documents, and investigation reports. Based on review of documentation the site is compliant with the intent of the provision. 115.401 (m). The auditor was provided private rooms throughout the site to conduct interviews. The staff staged the residents in a fashion that the auditor did not have to wait between interviews. The rooms provided for inmate interviews were soundproof and somewhat visually confidential from other residents which was judged to have provided an environment in which the offenders felt comfortable to openly share PREA-related content during interview. A review of the appropriate documentation and interviews with staff indicate that the site is in compliance with the provisions of this standard. No corrective action is warranted. 115.401 (n). Residents were able to submit confidential information via written letters to the auditing agency PO Box or during the interviews with the auditor. The auditor did not receive any correspondence from the site. Final Analysis: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with the standard.

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: · Website Findings (By Provision): 115.403 (a). The facility posts its PREA Audit reports on the Agency website. The reports are available for review at https://ctrenaissance.org/about/licensing-accreditation/prea/. There is a link to the final PREA reports. The facility is compliant with the intent of the standard.

	Final Analysis: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with the standard.

Appendix: Provision Findings		
115.211 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.211 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities?	yes
115.212 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities, including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.212 (b)	**Contracting with other entities for the confinement of residents**	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.212 (c)	**Contracting with other entities for the confinement of residents**	
	If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in	na

	emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	
	In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
115.213 (a)	**Supervision and monitoring**	
	Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes
115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	na
115.213 (c)	**Supervision and monitoring**	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing	yes

	staffing patterns?	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?	yes
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female inmates.)	yes
	Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female inmates.)	yes
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches of female residents?	yes
115.215 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility have procedures that enable residents to shower,	yes

	perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	
	Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?	yes
115.215 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?	yes
	If the resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.215 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
115.216 (a)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes

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

	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?	yes
115.217 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of	yes

	force, or coercion, or if the victim did not consent or was unable to consent or refuse?	
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes
115.217 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.217	**Hiring and promotion decisions**	

(f)		
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.217 (h)	**Hiring and promotion decisions**	
	Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.218 (a)	**Upgrades to facilities and technology**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012 or since the last PREA audit, whichever is later.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the	yes

	agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes

	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.221 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)	na
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	na

115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.222 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.222 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).)	yes
115.231 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents’ right to be free from sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with	yes

	residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
115.231 (b)	**Employee training**	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training,	yes

	does the agency provide refresher information on current sexual abuse and sexual harassment policies?	
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes
115.232 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.233 (a)	**Resident education**	
	During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes

	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes
115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.234 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent	yes

	the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	
115.234 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a).)	yes
115.235 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

	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
	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
	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
115.235 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	yes
	Do medical and mental health care practitioners contracted by	yes

	and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
	Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.241 (d)	**Screening for risk of victimization and abusiveness**	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:	yes

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

115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident’s risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Incident of sexual abuse?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness?	yes
115.241 (h)	**Screening for risk of victimization and abusiveness**	
	Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?	yes
115.241 (i)	**Screening for risk of victimization and abusiveness**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents?	yes
115.242 (a)	**Use of screening information**	
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?	yes

	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?	yes
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes
115.242 (c)	**Use of screening information**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems?	yes
115.242 (d)	**Use of screening information**	
	Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.242	**Use of screening information**	

(f)		
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
115.251 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.251 (b)	**Resident reporting**	

	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.252 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes
115.252 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve	yes

	with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	
115.252 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: a resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
115.252 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	yes
	If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension is 70 days per 115.252(d)(3)), does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes
115.252 (e)	**Exhaustion of administrative remedies**	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf	yes

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

	alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	
115.253 (a)	**Resident access to outside confidential support services**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes
115.253 (b)	**Resident access to outside confidential support services**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.253 (c)	**Resident access to outside confidential support services**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.261 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

	information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.261 (b)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.261 (c)	**Staff and agency reporting duties**	
	Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?	yes
	Are medical and mental health practitioners required to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.261 (d)	**Staff and agency reporting duties**	
	If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?	yes
115.261 (e)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators?	yes

115.262 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.263 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes
115.264 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate,	yes

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

	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?	yes
115.267 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency:4. Monitor resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?	yes

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

	evidence, including any available physical and DNA evidence and any available electronic monitoring data?	
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.271 (d)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.271 (e)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.271 (g)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.271	**Criminal and administrative agency investigations**	

(h)		
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.271 (i)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?	yes
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes
115.272 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.273 (a)	**Reporting to residents**	
	Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.273 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency	yes

	request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	
115.273 (c)	**Reporting to residents**	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.273 (d)	**Reporting to residents**	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform	yes

	the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	
115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.276 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.276 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.277 (a)	**Corrective action for contractors and volunteers**	

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

	condition of access to programming and other benefits?	
115.278 (e)	**Disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.278 (f)	**Disciplinary sanctions for residents**	
	For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.278 (g)	**Disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.282 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.282 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?	yes
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information	yes

	about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	
115.282 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na
115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive	na

	information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.286 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes

115.286 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.287 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287	**Data collection**	

(c)		
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.287 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.287 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.287 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	na
115.288 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes

115.288 (b)	**Data review for corrective action**	
	Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse?	yes
115.288 (c)	**Data review for corrective action**	
	Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.288 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes
115.289 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes

115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	na
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the	yes

	same manner as if they were communicating with legal counsel?	
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes