PREA AUDIT REPORT ☐ INTERIM ■ FINAL

COMMUNITY CONFINEMENT FACILITIES

NATIONAL PREA RESOURCE CENTER

BJA Bureau of Justice Assistance U.S. Department of Justice

Auditor Information			
Auditor name: Kevin Maurer			
Address: P.O. Box 4068, Deerfield Beach, FL 33442			
Email: kevin.maurer@us.g4s.com			
Telephone number: 954-790-3735			
Date of facility visit: 03/16/2015			
Facility Information			
Facility name: Hartford House			
Facility physical address: 10 Irving Street, Hartford, CT 06112			
Facility mailing address: *(if different from above)*			
Facility telephone number: 860-547-1313			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	■ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	■ Community-based confinement facility ☐ Mental health facility	☐ Other
Name of facility's Chief Executive Officer: Uduak Nguessan			
Number of staff assigned to the facility in the last 12 months: 13			
Designed facility capacity: 21			
Current population of facility: 20			
Facility security levels/inmate custody levels: Work Release			
Age range of the population: 18 - 65			
Name of PREA Compliance Manager:		**Title:**	
Email address:		**Telephone number:**	
Agency Information			
Name of agency: Community Solutions, Inc.			
Governing authority or parent agency: *(if applicable)*			
Physical address: 4 Griffin Road North, Windsor, CT 06095			
Mailing address: *(if different from above)*			
Telephone number: 860-683-7100			
Agency Chief Executive Officer			
Name: Robert Pidgeon		**Title:**	CEO
Email address: bpidgeon@csimail.org		**Telephone number:**	860-683-7100
Agency-Wide PREA Coordinator			
Name: Tyler Griffin		**Title:**	QA/PREA Coord.
Email address: tgriffin @csimail.org		**Telephone number:**	860-683-7100

AUDIT FINDINGS

NARRATIVE

Hartford House was audited March 16, 2015 by DOJ PREA Auditor Kevin Maurer. Prior to the on-site audit, a review of all pre-audit documents was completed. During the initial audit meeting, Tyler Griffin, PREA Coordinator, and Uduak Nguessan, Program Director, were present. A facility tour was conducted, which included all rooms of the program's facility and the outside grounds. During the tour, it was noted that the Notice of PREA Audit and other PREA related materials were posted in several locations.

Interviewees were identified from a list of staff and residents. The interviews included 11 residents and 9 staff which included all 3 shifts. Additionally, 5 specialized staff interviews were conducted. There had been 1 report of an alledged PREA incident, and there was 1 resident who identified with being LGBTI. All required policies, documentation, reports, logs and files were checked for compliance with PREA Standards.

It should be noted that the staff of Community Solutions, Inc and the Hartford House were very well prepared and organized for the on-site audit, and all pre-audit materials were in order and well highlighted. This shows the dedication and concern for the PREA program from both a corporate as well as a program level.

DESCRIPTION OF FACILITY CHARACTERISTICS

Hartford House is located in Hartford, CT in an older residential area. Hartford House is a three-story house with a basement and small outside area. The basement contains the laundry room and a computer/work area. The first floor consists of 3 bedrooms, a single use bathroom and two offices. The second floor has four bedrooms, a single use bathroom, the dining room and kitchen. The third floor consists of two bedrooms and the case manager's office. The outside area has a sitting/smoking area.

Hartford House is a female work release program that offers a continuum of gender specific services designed to prepare offenders for transition back into the community. Services include room and board, needs assessment and development of individual treatment plans, employment readiness, financial management, GED and housing referrals, cognitive-behavioral groups, problem solving life skills and individual and group counseling. The services at Hartford House are available to females ages 18 and over, who have been referred by the Connecticut Department of Correction. Candidates must be medically cleared within the last 12 months, and must be able to work full-time.

SUMMARY OF AUDIT FINDINGS

Community Solutions, Inc./Hartford House has a written policy for Zero-Tolerance toward all forms of sexual abuse and harassment. The Agency head, PREA Coordinator and facility staff are dedicated to providing a safe place for residents, one that is free from any abuse or harassment. The audit results show Community Solutions, Inc. and Hartford House are committed to the Zero-Tolerance policy within the program. However, there are several aspects of the Program Policy that are not fully compliant with PREA Standards.

During the 180 day corrective action period, the agency went through a change of PREA Coordinators. With the new PREA Coordinator in place, Community Solutions, Inc. implemented the corrective action. Many of the previous non-compliant standards are now in compliance with PREA standards. The remaining non-compliant standards are currently being addressed.

Number of standards exceeded: 2

Number of standards met: 28

Number of standards not met: 4

Number of standards not applicable: 5

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

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Solutions, Inc and Hartford House have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in the facility. This policy details the approaches it uses to prevent, detect and respond to sexual abuse and sexual harassment. The definitions of prohibited behaviors are clearly defined, as are the sanctions for those who violate policy.

The agency has designated the corporate Quality Assurance Coordinator as the agency-wide PREA Coordinator. He is knowledgeable of PREA requirements, devotes sufficient time and effort in assisting facility staff with PREA related issues, and has the authority to implement corrective actions. The PREA Coordinator reports to the agency CEO.

Standard 115.212 Contracting with other entities for the confinement of residents

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Hartford House does not contract with other entities for the confinement of residents

Standard 115.213 Supervision and monitoring

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Hartford House has a Master Staffing Schedule. There is a list of positions required for each shift, each day. There is no information regarding addressing the physical layout of the building, consisting of 3 floors. The Hartford House completed an annual assessment of the staffing plan on December 29, 2014.

The Hartford House has no cameras, therefore resident supervision relies entirely upon staff supervision. The Staffing Plan does not address staff conducting regular or random "rounds" to better monitor resident activities.

A recommendation was made to have a separate log to document Staffing Plan deviations.

While in the 180 day corrective action period, the policy was revised requiring documentation of deviations of the staffing plan on the deviation log. Additionally, policy section 2.5.12 was revised with the requirement of holding over staff to ensure appropriate staffing.

Standard 115.215 Limits to cross-gender viewing and searches

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy addresses resident searches and pat/pocket search and strip searches by same-gender staff. The policy does not address visual body cavity searches. Community Solutions does not permit cross-gender searches. Staff do not receive training on cross-gender searches as they are not permitted. The Program Policy additionally addresses cross-gender staff announcements. The Program Policy also prohibits the searching or physically examining a residents for the sole purpose of determining the resident's genital status.

Interviews with staff confirm that no cross-gender searchers are permitted and announcements are made by staff of the opposite sex prior to going into resident sleeping areas.

While in the 180 day corrective action period, the policy was revised requiring documentation of deviations of the staffing plan on the deviation log. Additionally, policy section 2.5.12 was revised with the requirement of holding over staff to ensure appropriate staffing.

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

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy states that clients admitted to a CSI program that are determined to have special comprehension needs due to organic, literacy or language barriers receive assistance to ensure comprehension. Staff should determine whether a client is capable of reading and comprehending documents necessary for program participation. If literary skills are inadequate, staff should read and explain all relevant written materials and assist the client with the sign in/out log to ensure the accuracy of all entries. Staff will make every effort through internal and external sources to accommodate any client unable to comprehend and speak English and assist such clients in achieving a level of comprehension necessary for the positive functioning in the program. This may be accomplished through the use of interpreters and/or translated forms. However, during the interviews it was discovered that staff do not know how to access additional services of an interpreter.

While in the 180 day corrective action period, the agency created a list of bilingual staff who are available to translate if necessary. Other interpreters may be provided by ABC Language Services after approval of the COO. A signed staff training roster was provided to show proof of staff training.

Standard 115.217 Hiring and promotion decisions

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy addresses the hiring and promotion duties. Policy and interviews indicate that the three questions regarding prior behavior of engaging in sexual abuse in a prison, jail, lockup,community confinement, juvenile facility or in the community is not a part of the promotion process. The Program Policy does not address sexual harassment incidents in deciding staff promotion. The Program Policy addresses background screenings for employees, but does not address these regarding contractors. Background checks are completed every two (2) years and vehicle driving records are verified annually. Employees are required to disclose any misconduct. Policy does not address termination for material omissions.

While in the 180 day corrective action period, Policy 2 was updated to include termination for material omissions by staff. The policy was not updated to include the three questions at the time of promotion or the reviewing of any sexual harassment incidents. It was reported that this is currently in the CSI legal department. While the PREA policy does address background screenings for contractors, there is no policy for this occurring.

Standard 115.218 Upgrades to facilities and technologies

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Hartford House has not had any upgrades to facilities and technologies.

Standard 115.221 Evidence protocol and forensic medical examinations

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Solutions, Inc and the Hartford House conducts administrative investigations only. The Connecticut State Police is responsible for conducting all criminal investigations. Community Solutions, Inc. has a letter confirming their request to Connecticut State Police requesting compliance with PREA. Additionally they have a Uniform Evidence Protocol that is utilized until Connecticut State Police arrive at the scene. The Hartford House offers all victims of sexual abuse access to Saint Francis Hospital for medical treatment and forensic medical examinations. Additionally, a MOU with CONNSAC provides for a advocate to accompany the victim. State Statute 19a-11a - provides that there will be no cost to any victim of a health care facility, and that all charges are to be forwarded to the Forensic Sexual Evidence account in the Judicial Department of the State.

Standard 115.222 Policies to ensure referrals of allegations for investigations

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Solutions, Inc / Hartford House Program Policy addresses their commitment to administrative or criminal investigations of all sexual abuse or sexual harassment allegations. The Program Policy dictates that a trained investigator shall conduct all administrative investigations; however all investigations shall stop if there is information regarding criminal activity. At this point, it shall be turned over to the Connecticut State Police. The agency does not have this policy available publicly.

While in the 180 day corrective action period, the agency updated their website with a PREA link that contains investigations of PREA allegations.

Standard 115.231 Employee training

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency provides PREA training for employees every 2 years. Refresher training is conducted monthly during the all staff meetings. The agency does not address Vulnerable Adult Abuse mandatory reporting in their training for staff.

While in the 180 day corrective action period, CSI updated their employee training regarding Vulnerable Adults. They provided a sign-in sheet identifying that staff have received refresher training on reporting abuse of vulnerable adults.

Standard 115.232 Volunteer and contractor training

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

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.

Program policy states that all staff, volunteers and interns must be trained to recognize and report abuse prior to their working with clients. Hartford House has one intern (volunteer). Training records show that the intern has received the required PREA training.

Standard 115.233 Resident education

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy addresses that all clients must be advised during their initial intake on the company policy against abuse and how to report incidents or suspicions of sexual abuse or sexual harassment, their right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and agency policies and procedures for responding to such incidents. It further states that client's who have transferred from a different Facility will receive refresher information about PREA during intake.

PREA specific training during orientation and subsequent house meetings includes information explaining the agency'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 regarding agency policies and procedures for responding to such incidents.

A CSI PREA brochure is provided to each resident during orientation, and additional PREA information is contained in the Program Handbook, as well as posted throughout the facility.

Documentation shows that all residents have received the required PREA training upon their intake into the facility. Resident interviews confirm training and topics.

Standard 115.234 Specialized training: Investigations

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA Coordinator is the agency's designated administrative investigator. He has receive specialized training through the Moss Group Training, Modules 1-9, in December 2014. All required areas of training were completed.

Standard 115.235 Specialized training: Medical and mental health care

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Hartford House / Community Solutions, Inc. does not have in-house medical and mental health care

Standard 115.241 Screening for risk of victimization and abusiveness

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

All residents receive a screening within 72 hours of intake. The objective screening tool utilized addresses all areas as required by standard 115.241, and addresses all prior acts of sexual abuse, convictions for violent offense and any prior history of institutional violence. Reassessments takes place within 30 days, or whenever there is an allegation that requires re-screening. The Program Policy states that there shall be appropriate controls on the dissemination of information, however, the controls were not identified in the policy. Additionally, the screening tool did not require a date or signatures of the staff and resident.

While in the 180 day corrective action period, the agency has worked towards finding a system for the dissemination of information to staff in order to provide appropriate protections for risk of victimization, but which does not exploit the resident. There is still on-going conversation at the agency level. Once a system is identified, the agency will need to train all staff.

Standard 115.242 Use of screening information

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy addresses utilizing the information from the risk assessment screening tool to making housing, bed, work and programming assignments. The Program Policy further addresses housing assignments for both transgender and intersex residents. However, there is no policy as to how this is completed.

While in the 180 day corrective action period, the agency has worked towards finding a system for the dissemination of information to staff in order to provide appropriate protections for risk of victimization, but which does not exploit the resident. There is still on-going conversation at the agency level. Once a system is identified, the agency will need to train all staff.

Standard 115.251 Resident reporting

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

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Community Solutions, Inc / Hartford House provides multiple ways for residents to report any sexual misconduct of other residents or staff. These include calling CONNSAC, calling the National Sexual Assault Hot line, telling a staff member, calling 9-1-1, and calling the PREA Coordinator. The brochure provided to residents only provides for reporting to staff.

While in the 180 day corrective action period, the agency provided proof of an MOU with CONNSAC (Connecticut Sexual Abuse Center) and has updated all postings and the brochure to include this information.

Standard 115.252 Exhaustion of administrative remedies

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

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.

During the initial on-site audit, this agency reported that it did not accept grievances as an approved method of reporting sexual misconduct. However, during the corrective action period, this auditor was provided a policy that meets all the requirements of the standard. The agency has not had a grievance filed that alleged sexual misconduct or imminent risk.

Standard 115.253 Resident access to outside confidential support services

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Residents may access outside confidential support services through CONNSAC or through the National Sexual Assault Hot line. Posters are used to keep resident's informed; however these posters do not address confidentiality, nor is it discussed with resident's at intake. Additionally, the residents have access to local community services on their own.

While in the 180 day corrective action period, the agency updated Sexual Abuse posters that include a statement of confidentiality.

Standard 115.254 Third-party reporting

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

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There is currently no information available to the public to address third-party reporting.

While in the 180 day corrective action period, the agency created a PREA link on their website that contains information for anyone to report any concerns of sexual misconduct.

Standard 115.261 Staff and agency reporting duties

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy requires all staff to report any allegations or information regarding sexual abuse, sexual harassment, retaliation or staff neglect which may have contributed to an incident or retaliation. Staff are prohibited from revealing information to anyone except on a need to know basis. All information reported is forwarded to the PREA Coordinator. The agency has not trained staff on Vulnerable Adult laws and mandatory reporting.

While in the 180 day corrective action period, the agency provided proof of training for all staff on State Statutes related to Vulnerable Adults.

Standard 115.262 Agency protection duties

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy states that if a client is in imminent danger of abuse or sexual abuse, staff will take the client to a staff area where the client will remain under constant supervision. Staff shall immediately contact the Program Director/Duty Officer to determine a safe location for the client pending an investigation. Additionally, the referring agency is notified and the offending resident is subject to removal from the program.

Standard 115.263 Reporting to other confinement facilities

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy provides that any information alleging a prior sexual abuse situation is immediately reported to the agency where the alleged abuse occurred. Notification is provided within 72 hours and is documented. There have been no instances of this at this program.

Standard 115.264 Staff first responder duties

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Program Policy requires that all steps of standard 115.264 are completed when an allegation of sexual abuse has been made. This is confirmed by interviews with staff. Non-security staff training does not address who to report to and that the non-security staff is required, until security staff arrive, to request that the victim not take steps that may destroy physical evidence.

While in the 180 day corrective action period, the agency provided proof of training for all staff on State Statutes related to Vulnerable Adults.

Standard 115.265 Coordinated response

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Hartford House has a Coordinated Response Plan that addresses all steps listed in standard 115.265, however the plan is not specific to the Hartford House program.

While in the 180 day corrective action period, the agency updated the Coordinated Response Plan. It is now facility specific and includes contact information for facility notification.

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

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Hartford House is Non-Unionized, Non-Profit facility and does not enter into collective bargaining agreements.

Standard 115.267 Agency protection against retaliation

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Connections, Inc. / Hartford House Program Policy provides for protections of residents and staff from retaliation for reporting a sexual misconduct. The PREA Coordinator is responsible for the monitoring of retaliation, and will monitor for 90 days or longer based on findings. Periodic checks are a part of the monitoring process. The PREA Coordinator was able to articulate the multiple protections that are utilized by the agency.

Standard 115.271 Criminal and administrative agency investigations

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Solutions, Inc/Hartford House does not conduct criminal investigations regarding sexual abuse. Criminal investigations are conducted by the Connecticut State Police and administrative investigations are conducted by the referral source. There is one employee who has completed the specialized training who conducts investigations regarding sexual harassment. When outside agencies investigate, policy requires all staff to cooperate with these investigations.

Standard 115.272 Evidentiary standard for administrative investigations

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy requires a standard of preponderance of the evidence when determining that an allegation of sexual harassment is substantiated. Interview with Investigative Staff confirms this.

Standard 115.273 Reporting to residents

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy addresses that a resident be informed of the outcome of the investigation at the conclusion. The policy does not address if the alleged perpetrator was a resident. All notifications are required to be documented.

While in the 180 day corrective action period, the agency updated their policy to include informing residents at the conclusion of an allegation when the alleged perpetrator is a resident.

Standard 115.276 Disciplinary sanctions for staff

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy identifies sanctions/discipline for staff who have violated the agency sexual abuse or sexual harassment policies, including progressive discipline for those who violate agency policy. Substantiated findings for sexual abuse shall result in termination.

Standard 115.277 Corrective action for contractors and volunteers

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Solutions, Inc/Hartford House prohibits any contractor/volunteer from engaging in sexual abuse with a resident. Any contractor/volunteer found to have violated this policy shall be reported to law enforcement, if criminal, and shall be prohibited from entering the facility. The Program Policy does not address notification to any licensing bodies.

While in the 180 day corrective action period, the agency updated their policy to include that licensing bodies will be notified in the event of sexual allegation investigation and outcome.

Standard 115.278 Disciplinary sanctions for residents

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Disciplinary sanctions for residents are determined by the Department of Corrections or Federal Bureau of Prisons.

Standard 115.282 Access to emergency medical and mental health services

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy requires that all resident victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services. Medical treatment is provided at St. Francis Hospital, and there is an MOU in place for a victim advocate. The agency offers no services in-house and victims shall be referred to outside resources. Treatment services are offered at no cost to the victim.

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

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Policy addresses that Hartford House shall offer medical and/or mental health evaluation to a client who has been the victim of sexual abuse. If the client requests medical and/or mental health care, any costs accrued from medical and mental health care following a claim of sexual harassment and/or sexual abuse is not the responsibility of the client. This includes any emergency treatment, ongoing medical or mental health treatment, follow ups, pregnancy tests and Sexual Transmitted Tests, regardless if the client names the abuser or not. All medical and mental health care is referred out to community based services.

Standard 115.286 Sexual abuse incident reviews

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Community Solutions, Inc Program Policy has a system to conduct incident reviews. However, not all areas of standard 115.286 are documented in the Program Policy.

While in the 180 day corrective action period, the agency created a form to be used that meets all the criteria of standard 115.286.

Standard 115.287 Data collection

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Solutions, Inc. Program Policy addresses the collection of data which is listed in standard 115.287. However, the information presented is not broken down by facility.

While in the 180 day corrective action period, the agency created and maintains a database that meets the criteria required by standard 115.287. All areas of the SVS are listed, and are broken down by facility. No contracted facility information is included, as they do not contract for the confinement of residents.

Standard 115.288 Data review for corrective action

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Solutions, Inc. maintains an annual report on its website. The information presented does not address allegations by facility, but instead it addresses allegations by referral source. While information is present for 2013 and 2014, there is no information as to the corrective actions and an assessment of progress in meeting PREA standards.

While in the 180 day corrective action period, a report was provided that meets some of the requirements of the standard. However, it does not identify allegations by each facility, does not address prior year allegations against current year allegations, and corrective action taken for both facility and agency wide.

Standard 115.289 Data storage, publication, and destruction

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Community Solutions, Inc. maintains data as outlined in the standards. However, this information is available on their website, however the information is not specific to each facility.

While in the 180 day corrective action period, a report was provided that meets some of the requirements of the standard. However, it does not identify allegations by each facility, does not address prior year allegations against current year allegations, and corrective action taken for both facility and agency wide.

AUDITOR CERTIFICATION

I certify that:

- ■ The contents of this report are accurate to the best of my knowledge.
- ■ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ■ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Kevin M. Maurer 10/16/2015

Auditor Signature Date