PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 12/27/17

Auditor Information			
Auditor name: Talia Huff, Mohamed Jaffer			
Address: Po Box 393, Larned, KS 67550			
Email: talia360cc@gmail.com, mojaffer8@gmail.com			
Telephone number: 785-766-2002			
Date of facility visit: 1/17/17-1/19/17			
Facility Information			
Facility name: APT Residential Services			
Facility physical address: 54 East Ramsdell St, New Haven, CT 06616			
Facility mailing address: *(if different from above)* 1 Long Wharf, Suite# 321, New Haven, CT 06511			
Facility telephone number: 860-575-2728			
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: Dan Iead			
Number of staff assigned to the facility in the last 12 months: 43			
Designed facility capacity: 125			
Current population of facility: 103			
Facility security levels/inmate custody levels: Min			
Age range of the population: 18-64			
Name of PREA Compliance Manager: Alissa Williams		**Title:** Clinical Supervisor	
Email address: awilliams@aptfoundation.org		**Telephone number:** 203-781-4600	
Agency Information			
Name of agency: APT Foundation			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 1 Long Wharf, Suite# 321, New Haven, CT 06511			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 860-575-2728			
Agency Chief Executive Officer			
Name: Lynn M. Madden		**Title:** President/CEO	
Email address: lmadden@aptfoundation.org		**Telephone number:** 203-781-4600	
Agency-Wide PREA Coordinator			
Name: Bob Freeman		**Title:** Compliance Officer/Director, PREA Coordinator	
Email address: bfreeman@aptfoundation.org		**Telephone number:** 860-575-2728	

AUDIT FINDINGS

NARRATIVE

APT Foundation hired a PREA audit to be conducted of the APT Foundation Residential Services Division in Bridgeport, Connecticut. This audit was conducted January 17-19, 2017, by certified PREA auditors Talia Huff and Mohamed Jaffer. APT Foundation is a community-based organization that offers a variety of services and programs to promote the health and recovery for those who live with substance use disorders and/or mental illness, which is also part of their mission statement. APT operates one residential facility; APT Residential Services Division located in Bridgeport while the main operations and administration is located in New Haven, CT.

More than six (6) weeks prior to arriving on site, auditors provided an Auditor Notice to be posted in all living units, facility entrance, visitation areas, medical areas, mental health areas, and other common areas. Confirmation of these notices being posted was provided to auditors on 12/6/16. As was noted throughout the site review, Auditor Notices were posted at the facility entrance and in each living unit. Pre-audit documentation was provided on the Online Audit System (policy only) and additional supporting documentation was provided via email to the auditors. Correspondence between the auditors and the PREA Coordinator occurred throughout the pre-audit phase. Prior to arrival, the auditors submitted a tentative audit schedule to the facility to outline audit activities for the onsite portion. On January 17, 2017, auditors reported to APT Foundation Residential Services Division to initiate the audit. An opening meeting was held with leadership. Present for the opening meeting was: Bob Freeman, Director of Clinical Operations/Compliance Coordinator/PREA Coordinator; Dan Iead, Director of Residential Services (Facility Head); Alissa Williams, Clinical Supervisor/PREA Compliance Manager; as well as other supervisory staff.

Auditors then conducted the site review (performance-based tour) of the physical plant, accompanied by the PREA team. The site review spanned the entirety of the building which contained all living areas, recreation areas, dayrooms, kitchen, office areas, breakroom, maintenance area. PREA signage was evident throughout the facility, ensuring that reporting information was adequately visible for all residents, staff, and visitors as well. Auditors noted some physical barrier issues throughout the site review and discussed those with the PREA team such as blind spots and isolated areas, areas with no camera coverage, etc.

Positive things noted on the site review were:

- PREA signage (English and Spanish), which contained internal and external methods of report
- Access to the stairwell is managed by an effective alarm system
- Staff/resident interactions were positive ad respectful
- Solid practice of staff announcements upon entrance to living areas
- Kitchen space very open

Opportunities for improvement as noted on the site review:

- Physical plant is not ideal for maximizing supervision
- Living area layout: (2) 3-man dorms are connected by one common bathroom
- Camera coverage in all hallways (none in rooms or bathrooms), but little camera coverage elsewhere
- Several offices and rooms (with no windows) are accessible by staff leaving the potential for staff/resident isolation/abuse to occur
- Laundry area has no cameras with many blind spots and is isolated with little supervision
- No use of mirrors to enhance vision/supervision

Following the site review and over the 3 days onsite, interviews of leadership and specialized staff were conducted. The PREA Coordinator was available at all times for auditor clarification and consultation and helped to ensure an efficient audit. Residents were chosen by auditors at random as well as targeted residents for interviews. Random staff (from all shifts) were chosen by auditors and interviewed. Staff and residents were familiar with PREA, though, the facility is relatively early in their PREA compliance. Residents appeared to have a high level of trust and respect

for the staff and leadership.

The second day of the audit, auditors also visited the central office/administration building located in New Haven, CT. Records review, site review, and interview of Human Resources was conducted. This location is where out-patient programs and services are provided along with evaluation and assessment of Residential Services residents. Shortly after intake, residents are transported from APT Residential Services to New Haven for medical/mental health/program needs and assessment are assessed.

Internal investigation of sexual abuse/harassment is conducted on-site by the PREA Coordinator. Cases involving criminal behavior and those requiring evidence collection/forensic examination are referred to Connecticut State Police for investigation.

DESCRIPTION OF FACILITY CHARACTERISTICS

APT Residential Services Division provides services to male and female clients and has a full capacity of 125 beds. It is a non-secure facility with minimal electronic and non-electronic (mirrors) surveillance. Resident supervision is provided by all staff, but mostly by Patient Care Associates (PCA's) and consists of observation in common areas and resident room visits (male staff for male units and female staff for female unit).

The average daily population during the twelve (12) months prior to the audit was 103. The actual population on the first day of the audit was 96, of which 66 (24 females and 42 males) fell under PREA Community Confinement standards as they were placed pursuant to the criminal justice system. The average length of stay in the last 12 months was 45 days. Residents are placed by the Connecticut Department of Correction, Probation and the court system in lieu of serving time in jail, prison or other form of confinement.

The facility consists of four (4) floors. The first (Ground) floor houses the kitchen, dining room, reception area (main entrance), intake/operation, facilities management, resident laundry room and staff offices. This floor does not house any residents and there are no resident sleeping accommodations. One half of the second floor consists of the medical/nursing unit for medical examination, specimen collection and medication dispensing. The other half of the second floor is rented to another agency and is locked and separated from the rest of the floor. The third floor consists of 36 bed female unit with 12 rooms (3 residents per room), group therapy rooms, art therapy, recreation, gym rooms and staff offices. A male unit with 20 beds (7 rooms) is also housed on the third floor. It is separated from the female unit with a door requiring electronic identification to open. The male unit also houses staff offices, group therapy room, gym and recreation rooms. The entire fourth floor consists of a male unit with 69 beds (23 rooms). The floor also houses staff offices, group therapy rooms, gym and recreation rooms. Each room shares a full bathroom with an adjoining room. Maximum of six (6) residents can share one bathroom.

Minors under 18 and those with intellectual disability, other physical disability requiring skilled nursing care, unstable medical conditions and hearing impaired (those who cannot take care of themselves and need assistance) are not accepted into the program. APT only accepts adult residents who speak English and Spanish and meet admission requirements. Average male resident age was 35 with a range of 21 to 65 years old while the average female resident age was also 35 with a range of 21 to 54 years old. There were no transgender or intersex residents in the last 12 months and during the audit period, but APT would accept these residents if they meet admission requirements.

Medical, Mental Health, Addiction services, Group therapy, Art therapy and Methadone Maintenance are provided on-site. Alcoholic Anonymous (AA) meetings are also available on-site and provided by an outside organization. If residents require specialized medical care or other clinical care not available on-site, they would be escorted by staff to their community Provider or APT Clinic in New Haven, CT. Employment assistance, career counselling, resume writings, interviewing techniques and other employment related services are also available for residents who choose to seek employment upon discharge from the facility.

SUMMARY OF AUDIT FINDINGS

At the time of the Interim Report:
Auditors found the APT Foundation Residential Services Division to be a facility that is progressive and successful in its mission to promote the health and recovery for those who live with substance use disorders and/or mental illness. The leadership and staff are very committed to the safety and well-being of their residents. The facility has relatively little staff turn-over, which correlated with what auditors observed; a positive morale. The facility is, however, early in their PREA compliance efforts and has a journey ahead in order to permeate and institutionalize the PREA standards into the facility culture and daily operations.

There were no (0) standards exceeded, seventeen (17) standards met, and twenty-two (22) standards not met.

At the time of the Final Report:
As indicated in the Interim Report, much corrective action was needed in order for APT Foundation to implement and institutionalize the PREA Standards. The concept of institutionalization was discussed at length throughout all phases of the audit and through the corrective action period. Further, the need to receive corrective action documentation as early in the corrective action period as possible was also conveyed. This way, auditors would have the opportunity for review and the agency would have the ample time to make additional revisions, changes, and adjustments based upon auditor feedback and still have the necessary time to demonstrate institutionalization. Nevertheless, no corrective action documentation was received until the latter part of the corrective action period, despite many emails from the auditors, prompts, reminders. Due to this, a phone call was requested with the PREA Coordinator, Facility Head, and Agency Head and this call occurred 7/26/17. The corrective action plan, deadlines, and requirements of demonstrating institutionalization were discussed as was the fact that it would be very difficult to demonstrate institutionalization for many standards given there was less than two months remaining in the corrective action period, which was to end on 9/20/17. Some documentation was emailed on 8/4/17 and 8/10/17. More documentation was emailed on 9/5/17 to include training records as well as risk plans (which, compared to other PREA Standards, require a longer period of institutionalization). The final email containing documentation were sent 9/19/17. Moreover, no time was allowed for review, revision, and institutionalization of the required corrective actions. That said, the APT Foundation is much closer to full implementation of the PREA Standards now. This Final Report details several areas that only require a period of institutionalization and few areas that still require further action. As discussed through this audit process, the PREA Standards are really a measure of performance and practice, not just policy.

There were no (0) standards exceeded, thirty-four (34) standards met, and five (5) standards not met.

Number of standards exceeded: 0

Number of standards met: 34

Number of standards not met: 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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Organizational Chart
- Code of Ethical Conduct and Compliance Plan
- Training documentation

Interviews, Document and Site Review:

APT Residential Services Division (RSD) has a PREA Policy. The policy follows the PREA standards numerically and largely cites the verbiage in the PREA standards. In some places, the policy addresses facility-specific methods of compliance, though, additional facility-specific methods of compliance would strengthen this policy. The effective date of the PREA Policy is unclear, as it is not stated on the policy itself. The policy states that the agency has a zero tolerance toward all forms of resident sexual abuse and sexual harassment and further alludes to the Code of Ethical Conduct and Compliance Plan, which outlines appropriate conduct by employees and rights of persons served. Under the 115.211 heading in the policy, there are definitions for Sexual Assault, Nonconsensual Sexual Acts, Abusive Sexual Contacts, Staff Sexual Misconduct, Staff Sexual Harassment, and Staff/Client Relationship. Some of those definitions mirror definitions from the older version of the Survey of Sexual Victimization. However, they do not encompass resident-to-resident sexual harassment. It is strongly recommended that the definitions mirror the definitions of sexual abuse and sexual harassment in the PREA standards. Furthermore, currently APT's PREA Policy includes responses to all questions on the Pre-Audit Questionnaire including data such as the number of searches conducted, number of background checks completed, etc. Since this data is ever-changing, it should be omitted from policy language. Including additional facility-specific methods of compliance would enhance the policy by further outlining the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment and further outlining a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

Interviews with random staff, residents, and specialized staff affirmed the zero tolerance policy and measures of prevention, detection, and response strategies.

APT Foundation has appointed an upper-level PREA Coordinator who also serves in the position of Compliance Officer/Director; Bob Freeman. Bob reported that he has sufficient time and has authority to develop and oversee agency PREA compliance efforts. Auditors reviewed the agency organizational chart, which listed the PREA Coordinator (PC) position. The PREA Coordinator reports directly to the President/CEO, Lynn M. Madden. Once onsite, auditors learned that Alissa Williams is the PREA Compliance Manager (PCM). Though, APT only operates one facility and the community confinement standards do not require a PREA Compliance Manager, Alissa Williams serves in this capacity since the PC is not located at the facility. The PCM also holds the title of Clinical Supervisor. Auditors also felt designating a PCM was necessary not only to handle allegations onsite but also to aid in PREA

compliance efforts onsite. The PCM was not listed on the agency organizational chart.

Corrective Action:

1. Enhance the PREA Policy to include additional facility-specific methods of compliance and by omitting data/dynamic elements from the policy.

Update on Corrective Action:

1. Auditors and PREA Coordinator had many discussions about APT's PREA policy. While onsite recommendations were provided for consideration and throughout the corrective action period, revisions were sent by the PREA Coordinator for review and feedback. The revised PREA policy now includes facility-specific language regarding compliance efforts rather than just citing the verbiage of the PREA standards. The policy now contains appropriate effective date(s). In addition, the definitions of sexual abuse and sexual harassment were revised to mirror the more accurate definitions in the PREA standards; to include resident-on-resident sexual harassment. The dynamic information that was previously included in the policy (to address questions on the Pre-Audit Questionnaire), including data such as the number of searches conducted and number of background checks completed was removed since this data is ever-changing. The revised policy has also now been enhanced to further outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment and further outlining a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

   In June 2017, auditors made a second onsite visit to reassess and to conduct necessary additional interviews with which to assess the status and progress of ongoing corrective action. There was minimal evidence of progress at that time, therefore, auditors conducted additional interviews via telephone and web meeting on August 18, 2017, which affirmed that training sessions were delivered by the PREA Coordinator to all staff that, in part, addressed changes to the PREA Policy. Random staff that were interviewed on August 18, 2017, accounted for the content of this training. Training documentation was also provided by the PREA Coordinator for verification.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT Residential does not contract with private agencies or other entities for confinement of residents. The APT PREA Policy for this standard states that APT Residential "is the only facility that requires PREA audit due to

contracted beds with the Department of Corrections (DOC); Court Support Services Division (CSSD); and Federal Probation beds."

Contracts (or verbal/informal agreements) under this standard refer only to the confinement of APT residents at other confinement facilities and not contracts or agreements to house residents *at* APT. Therefore, this language can be omitted from the APT PREA Policy.

Auditors had discussions with the PREA Coordinator and Facility Head regarding the interpretation of this standard and to gather information about APT practices regarding possible informal agreements that may be applicable to this standard. It was verified that APT does not have such agreements in place.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
APT PREA Policy for Supervision and Monitoring states that APT will maintain a staffing pattern that meets all regulatory requirements for ASAM Level 111.3 facility and based on a full licensed capacity of 125 beds. The policy does not mention any PREA considerations in developing staffing plan or levels of staffing.

APT has a staffing plan to provide residential drug rehabilitative services, but does not have a staffing plan that considers the elements of this standard for adequate levels of supervision and monitoring.

APT did not provide documentation of a staffing plan that showed adequate staffing through a lens of sexual safety and using video monitoring, where applicable, to protect residents from sexual abuse. No documentation was provided to demonstrate consideration of facility physical plant layout, composition of the resident population or prevalence of substantiated and unsubstantiated incidents of sexual abuse.

Discussion of this standard with the Director of Residential Services and the PREA Coordinator revealed that APT has meetings and discussions regarding staffing, but not specifically concerning sexual safety and the elements of this standard in developing their staffing plan/levels.

This standard also requires that APT document and justify deviations from this staffing plan, which was not provided.

Additionally, APT must conduct a staffing plan review at least annually, in consultation with the PREA Coordinator, in order to assess needed adjustments, which was not provided.

Of note, APT is planning to move their present residential facility to a new location in the very near future. Reportedly, the new location is more conducive to providing resident supervision. With this information, APT will need to develop and document a staffing plan/levels based on this standard that considers the required elements of provision (a); physical plant layout, composition of resident population, prevalence of incidents of sexual abuse, and any other relevant factors.

Corrective Action:

1. Provide auditors with documentation of 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.
2. APT shall document and justify deviations from this staffing plan; i.e. when staffing levels go below the established minimum level.
3. APT shall conduct a staffing plan review and provide for auditor review. This shall be done at least annually, in consultation with the PREA Coordinator, in order to assess needed adjustments.
4. APT shall provide this staffing plan for the new APT facility.

<u>Update on Corrective Action</u>:

1. Auditors had many discussions with PREA Coordinator and Residential Director regarding the requirements of this standard; looking at staffing through a lens of sexual safety. Sample staffing plans were provided for APT's review and consideration. On 6/19/17, the PREA Coordinator provided a staffing plan document, which accounted for the required elements of this standard. This staffing plan elaborated on staffing coverage and staff-to-resident ratios, on-call coverage and scheduling, physical layout and composition of the resident population of the New Haven facility, prevalence of substantiated and unsubstantiated incidents of sexual abuse, video monitoring, and staffing plan annual review.
2. As stated the staffing plan provided, observed by auditors while onsite both times, and asserted in interviews with the PREA Coordinator and Residential Director, APT maintains staffing ratios that exceed minimum staffing required by their licensed level of care. There have been no deviations from the staffing plan. APT maintains a pool of per diem staff that ensure at least minimum staffing is maintained.
3. The staffing plan provided on 6/19/17 pertained to the New Haven facility. Since, in the midst of the corrective action period, APT relocated from a facility in Bridgeport, CT, to New Haven, CT, auditors required a second visit to see the new location and required that a staffing plan be provided that applied to the new location. This was to ensure the elements of this standard were considered and documented to account for differences in the new location. The new location offers a physical layout that has fewer physical barriers and is more conducive to resident supervision, enabling APT to create a more sexually safe environment.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- RSD Non-Invasive Pat Down Protocol

Interviews, Document and Site Review:

APT PREA Policy addresses this standard. It prohibits staff from conducting strip searches, visual body cavity searches or physical exam of a transgender or intersex resident or any resident for the sole purpose of determining the genital status. APT reported no (0) cross gender strip/pat down searches in the past 12 months. Strip searches, in general, are not conducted at APT. Upon returning to the facility from off-grounds, a cursory check for contraband may be conducted, which includes patting arms and legs and socks (but not near genital areas), having the resident empty pockets, and having the resident open/shake out their waistband. It is not a pat down search as typically seen at a correctional facility. No cross-gender search or pat down log maintained since cross gender searches/pat downs by staff are not allowed and there have been no (0) situations or exigent circumstances requiring any form of physical search or pat down by staff of residents of the opposite gender in the past 12 months.

All staff interviews confirmed that cross gender searches/pat down of residents, search or physical exam of a transgender or intersex resident for the sole purpose of determining the genital status is not performed and not allowed. In reference to provision (f), no pat down or strip search training curriculum or records were provided or reviewed since they are not conducted at this facility and because both policy and staff interviews corroborated this.

Staff of the opposite gender always announce their presence when entering an area where residents are likely to be showering, performing bodily functions or changing clothing. Auditors witnessed such announcements while touring the facility and all staff interviews also confirmed strict adherence with this procedure. Of note, only male staff work in male units and female staff work in female units, which is stated in policy. Staff of the opposite gender would only enter unit(s) of the opposite gender while on the way to another area of the facility and would announce their presence at the entrance corridor. Each residential room in the facility can accommodate up to 3 residents and shares a bathroom with a door that locks (shower, toilet and sink) with an adjoining room of residents that accommodates up to 3 residents. Six (6) residents can potentially share the same bathroom. There is no video surveillance or any other form of surveillance (mirrors, etc) to allow for any staff or other residents (including residents and staff of the opposite gender since only male staff work in male residential areas and female staff work in female residential areas) to view residents while showering or in a state of undress.

Corrective Action:

None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Resident Information Brochure (English and Spanish)
- PREA Posters (English and Spanish)

Interviews, Document and Site Review:

APT PREA Policy indicates that based on the comprehensive level of drug rehabilitation services they are required to provide to residents, admission to the program "may exclude persons with certain disabilities or who do not speak English or Spanish." Based on discussions with the PREA Coordinator, Facility Director, and Intake Coordinator, admission referrals for those who are deaf, hard of hearing, blind, low vision, intellectual, psychiatric or speech disabilities are generally not accepted into the program, though this is not expressly prohibited. The Intake Coordinator makes this decision for every admission referral via telephone and before the resident is admitted or physically present in the facility.

PREA Policy states, "APT Foundation recognizes that persons served may have limited reading comprehension in either English or Spanish and is prepared to accommodate these individuals through direct reading of consents, including PREA, and direct inquiry of comprehension."

Auditors learned that the facility has sufficient staff proficient in both English and Spanish and does not rely on other residents for interpreting, except in emergency situation after permission is obtained from the resident requiring interpretation. There has been no use of resident interpreters in the last 12 months, which was reported pre-audit and confirmed through staff interviews. The Resident Information Brochure is available in English and Spanish, which was provided for auditor review. In addition, PREA posters around the facility were in English and Spanish.

PREA education is provided through a variety of forums, including group discussions and individual counseling sessions. The individual sessions allow for residents with limited English proficiency to understand APT's policies on prevention, detection and response to sexual abuse and harassment. There were no residents, reported or observed by auditors, that were limited English proficient or that were deaf, hard of hearing, blind/low vision, or which had intellectual, psychiatric, or speech disabilities.

Corrective Action:

None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Review of Employee HR records/folders
- Employment application
- HR Manual section 108-Pre-Employment Requirements

Interviews, Document and Site Review:

APT PREA Policy states that they will not hire any individual or utilize contracting services that has engaged in sexual abuse in a prison, jail, lockup, community confinement or other institution. All provisions of this standard are cited in the PREA policies as part of their practice. APT hired 27 people for the residential facility and conducted 38 background checks in the last 12 months as per information listed in their PREA policy and Pre-Audit Questionnaire.

Auditors discussed the hiring process and background check procedure with the HR Director, who had been in the position for almost 5 years. Interview with the HR Director revealed that APT uses an outside firm to conduct background investigation for each applicant. She indicated that, based on her knowledge, applicant background checks were also conducted prior to her employment with APT but could not guarantee it was done and that she would be able to provide documentation. Employee files were chosen at random for auditor review. Many of the files were of employees who were hired prior to the employment of current HR Director did not have any evidence of background checks. Background check reports for these employees were requested (in case they were maintained elsewhere), but could not be produced by HR. Employee files that were chosen of employees that had been hired since the HR Director was in place did have background checks conducted upon hire and these files contained this documentation.

Pursuant to provision (c)(2), APT should make its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse or resignation during a pending investigation of sexual abuse. Admittedly, APT does not have this practice in place as reported by the HR Director and auditors found no such documentation in employee files.

This standard also requires criminal background checks be conducted of current employees and contractors (that have resident contact) at least every five years or have a system in place for capturing such information on current employees. There was no documentation in the employee files demonstrating this practice. The HR Director acknowledged that this practice is not yet in place, but understood the need to do so.

As required by provision (f), APT does not ask applicants any questions in their employment application or in person about previous misconduct or affirmative/ongoing duty upon employees to disclose any misconduct such as engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution. Auditors were provided the employment application for review and also reviewed applications in employee files. The required questions were not noted. No questions asked about conviction 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. No questions asked if applicant has been civilly or administratively adjudicated to have engaged in sexual activity.
Material omissions regarding such misconduct or the provision of materially false information as grounds for termination is not mentioned in their application in regards to sexual abuse, but is in their policy and was also reported as practice.

Pursuant to provision (h), APT has not received any request from institutional employers inquiring about former APT employees' involvement in substantiated sexual abuse or harassment. Neither APT PREA Policy nor APT HR Policy addresses provision (h) and the PREA Coordinator reported that their practice is only to disclose information about whether a former employee is considered re-hirable. Provision (h) requires a facility to disclose this information unless prohibited by law.

Corrective Action:

1. APT shall immediately review all current employee records to ensure that a criminal background check was conducted prior to hire. This shall apply to any employee that has any resident contact. In addition, APT shall ensure that all current employees have had a background check at least in the last 5 years. Any current employee who has not had a background check in the last 5 years shall have one conducted. APT shall put a system in place for doing this at least every five years moving forward. APT shall provide auditors with the action plan for accomplishing this and provide verification of such.
2. APT shall 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. It was agreed that APT will immediately begin obtaining this information for candidates they select for employment. It was discussed that this information will be requested in the offer letter to selected applicants and reviewed before employment begins. The offer letter will also contain statements about material omissions, false information and continuing affirmative duty to report such misconduct.
3. APT shall make its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse or resignation during a pending investigation of sexual abuse. Provide auditors with the method of requesting and documenting these requests and provide all completed examples of requests sent.
4. APT shall put a system for disclosing, upon request from another institutional employer, information regarding former employees being involved in substantiated allegations of sexual abuse or resignation during a pending investigation of sexual abuse, unless prohibited by law.

<u>Update on Corrective Action</u>:

1. Auditors met with and had phone calls with the PREA Coordinator and Human Resources staff to review this standard in detail and recommendations on how APT can become compliant. Though, it was reported by the Agency Head, HR staff, and the PREA Coordinator that backgrounds are completed for all staff members, documentation was not available or provided during the first or second onsite visit to demonstrate this practice. After the second onsite visit, APT conducted background checks on employees and provided a report from Research Services, Inc., which accounted for approximately 333 employees that had received background checks and APT reported that backgrounds on all employees had been conducted with the exception of one, who was out of extended leave. This was provided on 9/7/17 along with a sample background check report; Background Verification Report from Research Services, Inc. The Background Verification Report included a check of driving record, court record, and a National Criminal Index which indicated a check of nationwide criminal databases, nationwide sexual offender registry check and other federal and international agencies. In regard to recurring background checks, at least every five years, the HR Director has set up a system of tickler files in the electronic HR

system to prompt when recurrent/subsequent backgrounds are to be conducted. This corrective action item is satisfied.

2. A supplemental form was implemented to capture the 3 required questions pursuant to provision (f). The form also has language at the bottom regarding the employee's affirmative duty to disclose misconduct and that material omissions shall be grounds for termination. Auditors requested and received samples of completed forms on 9/7/17. Five completed forms were provided from the five recent hires. This form is sent and completed at the point at which a conditional offer of employment is extended to an applicant. This corrective action item is satisfied.
3. Revised policy language does not cite or address a system to contact all prior institutional employers for information on substantiated allegations of sexual abuse or resignation during a pending investigation of sexual abuse. APT expressed throughout the corrective action period that many organizations strongly limit the information they will supply as part of a reference check due to legal concerns. Guidance from the auditors clarified that the *receipt* of the information will not determine whether APT is compliant with this provision. Rather, it is APT's request of this information from prior institutional employers that is required. Even still, there seemed to be some reluctance in implementing this practice. Auditors requested the employment applications from recent applicants, of which there were five, as well as documentation of contact with prior institutional employers. Documentation of contact with one prior institutional employer was provided. No response from the employer was received by APT, though, the request was dated 9/14/17, only six (6) days prior to the end of the corrective action period. This practice has not been in place long enough to demonstrate institutionalization. Furthermore, it was noted that that two (2) of the applicants had prior institutional employers; one applicant had two prior institutional employers and one applicant had three prior institutional employers (though one of the prior institutional employers is no longer in business). Documentation of contact was only provided for one prior institutional employer when there should have been contact with four. Therefore, APT has not satisfied this standard as practice has not been in place long enough for institutionalization and because documentation was not provided for all prior institutional employers.
4. APT revised policy language to reflect, "APT Foundation typically only confirms dates of employment in requested reference checks. APT Foundation will, however, report cases of substantiated sexual abuse for former employees who apply to another institutional employer."

   APT reported there had been no such requests from other institutional employers. However, as this practice had only been put into place in September 2017, it was not in place long enough to demonstrate institutionalization. Through the corrective action period, APT voiced reluctance in disclosing this information since their practice has always been only to disclose dates of employment. Many emails and phone calls occurred between APT and the auditors. Numerous times concern was conveyed by the auditors that documentation of corrective action measures had not been provided to the auditors. Corrective action for this standard specifically was repeatedly discussed, though, documentation and demonstration of practice was not provided until September 2017 when the deadline for the corrective action period was 9/20/17. Auditors held a call on 9/19/17 with the PREA Coordinator and two HR staff in which it was reported that this practice began only a few weeks prior. Therefore, APT has not satisfied this standard.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

At the time of the Interim Report, APT had not acquired any new facilities or made any expansions or modifications to their existing facility in the past 3 years. APT Foundations Residential has now relocated to a different facility in New Haven, CT. One of APT's significant considerations of moving to this location, as expressed by the PREA Coordinator and Agency Head, was to benefit from the design/physical layout which increases the agency's ability to protect residents from sexual abuse (among other benefits). One example is that the new facility is single-story. The new facility, being a former residential facility, already had a system of video monitoring which is utilized as supplemental supervision and post-incident review.

Corrective Action:

None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Resident Information booklet
- Staff Training materials

Interviews, Document and Site Review:

APT PREA Policy addresses each provision of this standard. APT conducts administrative investigations while criminal investigations are referred to the Connecticut State Police. However, auditors were not provided with any documents outlining the agency's uniform evidence protocol. APT Policy does not specify procedure or charge any person with this responsibility, name(s) of any rape crisis organizations or an individual/title in the facility who can provide this service when indicated.

Regarding provision (b), APT does not provide services to minors. No protocol was provided in order to verify what source it was adapted from.

Interviews with the PREA Coordinator and Facility Director revealed that victims of sexual abuse requiring a forensic examination and evidence collection are sent to a local Hospital staffed with SANE/SAFE. APT has not referred any residents for forensic examination in the last 12 months.

APT PREA Policy states that a victim advocate, qualified agency staff member or qualified community-based organization member shall accompany and support the victim through the forensic examination process, investigatory interviews, provide emotional support, crisis intervention and referrals. During the onsite audit, the PREA Coordinator informed auditors that he had begun discussions with a local rape crisis center who was aware of PREA and receptive to establishing a relationship and MOU, though, no contractual/MOU agreement exists yet with external rape crisis organizations or documentation of efforts to obtain these services for victims of sexual abuse. Additionally, the Resident Information brochure does not mention the availability of victim advocate services. The PREA poster (posted in all areas and accessible to all residents) does not mention victim advocate services.

Interview with PREA Coordinator and Director of Residential Services alluded to victim advocate services being provided by one of their licensed mental health staff and residents can be referred to external (outside) advocate/crisis counselling services. This section of policy relating to investigation is quoted from the actual standard but has no specific information/procedure.

Interview with PREA Coordinator revealed that he conducts a preliminary internal investigation and refers to Connecticut State Police when indicated, but auditors were not provided with documentation that the agency has requested the State Police follow requirements of (a)-(e) of this standard.

Staff training documents mentions that APT will conduct an internal investigation for all sexual abuse incidents and APT investigation will be secondary if Connecticut State Police is deemed the investigating authority following an incident. PREA Coordinator mentioned that only incidents involving rape/penetration (oral, anal, vaginal) and forensic examination/ evidence collection cases would be referred to Connecticut State Police.
Provisions (g) and (h) are not applicable.

Corrective Action:

1. APT shall establish a uniform evidence protocol, which can be specified in PREA policy or another document. This should include specific procedure for the facility to follow.
2. APT shall attempt to establish an MOU with external rape crisis organization or documentation efforts if not able to obtain MOU. APT shall specify how they will attempt to provide victim advocacy, crisis intervention, and emotional support to victims of sexual abuse. Residents should be informed of these services.
3. APT shall request that the Connecticut State Police follow requirements of (a)-(e) of this standard. This can be done in the simple form of a letter or email.

Update on Corrective Action:

1. APT developed a uniform evidence protocol. Enhanced language elaborating on this protocol was included in PREA policy, which was provided to and approved by the auditors. Policy language states that APT utilizes the New Haven Police Department for sexual abuse investigations, particularly those that involve physical evidence and the policy language requires staff to secure the crime scene and remain with the alleged victim and abuser throughout the response process. This was included in PREA training that was provided to staff during the corrective action period. The training was delivered by the PREA Coordinator and documentation thereof was provided to the auditors. The documentation included the training content and attendees. In addition, additional staff interviews conducted via phone/web indicated staff awareness.
2. An MOU was established with the Women and Families Center; a community-based local organization. A copy of the MOU was provided for auditor review, contained signatures of parties from APT and the organization, and was dated 5/19/17. The MOU sufficiently outlined the responsibilities of both entities, confidentiality of residents, and that the organization will provide services pursuant to any forensic exam as

well as a 24-hour hotline for resident use. The PREA posters in resident areas was updated to include contact information for the Women and Families Center. Residents would receive this information as part of their orientation process and the information was also included in the Resident handbook under the PREA section and staff PREA training also included this information.

3. Once at the new facility, the criminal investigating agency became the New Haven Police Department. It was requested in writing by the PREA Coordinator that the agency follow the investigative requirements in the PREA standards. The request included the excerpt from the PREA standards and was the email correspondence was provided for auditor review.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Agency Website

Interviews, Document and Site Review:

When warranted, APT conducts an administrative investigation for reports of sexual abuse or sexual harassment, which is completed by the PREA Coordinator. Cases requiring a forensic examination/evidence collection or potential criminal behavior are forwarded to Connecticut State Police Department for investigation and possible referral for prosecution. PREA Policy and practice are established to ensure that an investigation is completed for all allegations of sexual abuse and sexual harassment. This was evident through interviews with the Agency Head, Facility Head, and PREA Coordinator. Auditors were only provided with PREA Policy; no policy that outlines and guides investigations.

APT reported 1 allegation of sexual harassment in the last 12 months, which resulted in an administrative investigation. There were no criminal investigation referrals. A copy of a full investigative report of the sexual harassment with findings was requested but not available to review. Therefore, auditors could not verify that an investigation was, in fact, completed in order to justify compliance with this standard.

Provision (b) requires that the policy mandating investigations for sexual abuse and sexual harassment is published in the agency website. While the agency website does mention that any allegation of sexual abuse or harassment may result in referral for criminal investigation by the CT State Police or other legal authority, policy was not found and there was no documentation of specific responsibilities of the separate entity that conducts criminal investigations for the agency. Though explained by the PREA Coordinator, it must be on the website.

Documentation of referral of sexual abuse/harassment allegation was not available since no referrals for criminal investigation made in the last 12 month. It is recommended that APT develop a standard referral documentation form or procedure for obtaining written documentation to verify referral.

Corrective Action:

1. APT shall provide investigative material for the sexual harassment allegation and any other investigations of sexual abuse or sexual harassment during the corrective action period.
2. APT shall publish their PREA Policy on the agency website and it shall describe the investigative responsibilities of both the agency and external investigative entity.

Update on Corrective Action:

1. APT provided investigative documents for the sexual harassment allegation, which was reviewed by auditors and discussed with the facility. Since the incident occurred prior to having institutionalized an investigative protocol, documentation was incomplete in terms of including information on all interviews conducted, all sources of evidence used and obtained to make investigative findings, and a case disposition. It was stated that the incident was unfounded, though, documentation provided did not seem to support this finding since the disposition of "unfounded" would indicate that APT was able to prove that the incident did not happen. From review of the documentation provided, unsubstantiated appeared to be more justified. Nevertheless, corrective actions pursuant to this audit now gives the foundation and guidance for a formalized and uniform administrative investigative process.
2. APT updated its website to publish their PREA and a description of the investigative responsibilities of both the agency and external investigative entity. Auditors verified the information on agency website: https://aptfoundation.org/wp-content/uploads/2017/09/PREA-Policies-ilovepdf-compressed-1.pdf

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Training materials
- PREA Acknowledgement Form

Interviews, Document and Site Review:

APT PREA Policy cites each provision of this standard. Auditors learned that all APT Residential Facility staff view a generic video on PREA and sexual abuse (not specific to APT). It was notes that the video was developed for

inmate/resident PREA orientation and not for staff orientation, but is an excellent video. Also, the PREA Coordinator conducts staff PREA training in group meetings with staff.

Auditors reviewed 3 different staff training materials provided by PREA Coordinator – PREA Staff Orientation Power Point presentation, Staff Education PREA Policy Highlights and Staff meeting notes. The PREA written training curriculum or the video does not cover all the 10 elements of this standard. The following elements were not present – Dynamics of sexual abuse, how to avoid inappropriate relationship with residents, how to communicate effectively and professionally with residents including LGBTI and gender non-conforming residents (115.231 (a) - (5), (8) and (9).

Training is tailored to gender of the resident population.

Documentation of employee signature that they understand the training they have received is maintained and was reviewed. Employees sign a PREA Acknowledgement form, which states the required language stating that the employee has received and understands the training.

Random staff interviews revealed a high level of importance of resident safety and all had watched the PREA on-line video and some received face to face APT specific PREA training. With not all training elements being included in the training material, staff did not articulate all required training elements. Training should be enhanced to include all elements.

Corrective Action:

1. Develop one unified/standardized training for all staff to include all the elements of this standard.
2. Ensure staff comprehension and ability to articulate all required training elements. Based on staff interviews, it is not clear which training materials each staff member received or which training they attended.

Update on Corrective Action:

1. Auditor had numerous conversation with PREA Coordinator to provide guidance for this standard. The PREA Coordinator modified and developed staff PREA training curriculum and provided for auditor review. During the second onsite visit, auditors reviewed and provided additional feedback which was subsequently incorporated and implemented. This revised training was then delivered by the PREA Coordinator to all staff.
2. Training documentation was provided for auditor review to include the training content and attendees. One unified Staff PREA training was updated/revised to include all the requirements of the standard and specific APT policies and procedures. Additionally, interviews conducted via phone and web 9/18/17 affirmed that staff had received the training, affirmed it was delivered by the PREA Coordinator, and included information that was not present in the original training.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Visitor/Contractor Reception sign-in sheet

Interviews, Document and Site Review:
APT does not generally utilize volunteers in the Residential Facility, which is stated in PREA Policy. Contractors, when utilized for short term or emergency repairs, are advised of PREA upon entrance to the facility and work is done under staff supervision. Auditors observed the PREA information present around the facility as well as at the facility entrance where all people sign in, prior to entering.

APT reported that the Residential facility has not utilized a contractor in the last 12 months.

The PREA information for contractors which requires their signature was reviewed and complies with standard, though auditors did not receive a copy of this form, which is needed for the audit file.

There was no documentation available for contractors or volunteers since APT did not utilize a contractor in the last 12 months.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Resident Information Handbook

Interviews, Document and Site Review:
APT PREA Policy addresses the way in which PREA education is administered. The Resident handbook contains PREA information to meet this standard. Residents receive face to face PREA training at Intake and then again on a periodic basis by their Clinician.

APT maintains only one residential facility so refresher information is not required for transfer to another facility.

APT reported that 960 residents received PREA **information** at admission in the last calendar year while 509 residents received PREA **education** at the completion of their master treatment plan which is completed within the first 30 days.

APT does not admit residents who are otherwise disable, deaf, visually impaired or those who do not speak English or Spanish, although PREA policy indicates that PREA education is provided to residents who are deaf, visually impaired or with other disability. See 115.216 for additional auditor comments. Residents with limited English or Spanish comprehension receive appropriate PREA education as per staff interviews.

Documentation of resident PREA education is maintained in the residents' electronic health records. While auditors reviewed PREA education records electronically. it is recommended that APT use a system in which these education records can be better documented, tracked, and monitored.

Not clear if a compliance report can be generated from electronic health records to specifically capture information to ensure all residents receive the proper education as per policy, but all staff and resident interviews confirmed resident education.

Sexual abuse/PREA posters and resident handbook available in all residential locations (witnessed during site tour) and the information contained meets standard.

Recommendations include 1) removing information in APT PREA Policy about providing education to residents with other disability, deaf, visually impaired since APT does not admit these residents, 2) Consider another system to document completion of resident education in order to better monitor compliance, 3) Enhance the PREA information in the Resident Handbook to include additional methods of report (that are listed on the PREA posters), emotional support, etc.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Documentation of NIC training

Interviews, Document and Site Review:
APT conducts internal investigation of cases that do not involve a forensic exam/evidence collection or involve criminal behavior. They are referred to Connecticut State Police for investigation.

The PREA Coordinator is the only individual in the agency that completed the specialized investigations training via the National Institute of Corrections that covers all the required elements of investigation training including Garrity warnings, proper use of Miranda, evidence collection in confinement settings and evidence required to substantiate a case. Documentation of this training was provided. He is the only individual who conducts internal administrative investigations (not involving forensic examination/evidence collection or criminal behavior). No other individual completed the specialized training. It is recommended that another person is trained and charged with this duty in the PREA Coordinator's absence. Although APT does not conduct criminal investigations, it would be beneficial to have another individual completed the specialized training such as the Social Work Supervisor who also functions as the PREA Compliance Manager and is physically present in the facility.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
No (0) Medical or Mental Health staff completed the specialized training at the time of the onsite audit. Medical and mental staff were interviewed and affirmed this to be true.

Corrective Action:

1. APT shall have all medical and mental health staff complete specialized training. Information about completing this training on-line, free of charge via the national Institute of Corrections was provided to the PREA Coordinator and Residential Director.

<u>Update on Corrective Action:</u>

1. Documentation (On-line certificate of completion) was received showing that all medical and mental health staff assigned to the residential facility completed the required training was completed via National Institute of Corrections (NIC). This was provided for auditor review on 9/5/17.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Intake screening and other forms

Interviews, Document and Site Review:

The PREA policy cites all provisions of this standard but does not specify the procedure for compliance. In the last 12 months, 693 residents were screened prior to admission. Currently, screening is done via telephone before resident is accepted. The screening that is currently being done does not comply with this standard as it does not contain all required elements, cannot be done over the phone, is not objective, and is not for the purpose of establishing a risk of sexual victimization or abusiveness. Much discussion was had with facility staff and leadership regarding the intent and use of this standard and a proper screening instrument as guided by this standard.

The telephone intake screening form that is completed before a resident is accepted to the facility asks the following screening questions – Sexual offense charge/incarceration, aware of PREA, ever been a victim of sexual abuse, ever accused of sexual abuse or harassment, sexual orientation and gender identity (done within 72 hours and before resident is admitted). This form also contains many other questions not related to sexual abuse/this standard.
The following questions are not specifically asked and other similar questions would not reveal this information - whether the resident has a mental, physical, or developmental disability**, t**he physical build of the resident, whether the resident's criminal history is exclusively nonviolent, whether the resident has prior convictions for sex offenses against an adult or child (asks of any prior sex offenses only), whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, the resident's own perception of vulnerability.

Policy states that these remaining questions are asked as part of the developmental evaluation by a Clinician at a later time and documented in the resident's health records. Review of the Clinician admission evaluation form revealed that not all of the missing screening questions are captured on this form – such as physical build, intersex, is criminal history exclusively non-violent. All of the screening elements should be considered together and should culminate into a determination of sexual risk.

There was no documentation to show that risk re- assessment was completed within 30 days based upon additional information received since intake screening and no separate documentation available for 115.241(g) and (h), although they are mentioned in the PREA policy.

The decision making at the end of the intake screening form are as follows – Placed on waiting list, Needs follow-up, Denied/Reasons and nothing relating to sexual victimization/abusiveness.

Corrective Action:

1. Implement an objective screening instrument which contains all required screening elements and culminates in a determination of risk of sexual victimization and abusiveness. Provide auditors with a proposed screening instrument prior to implementation and upon approval, institutionalize procedures for screening all residents

after intake. APT should develop a system to monitor this standard and documentation for compliance.

Update on Corrective Action:

1. Auditors assisted APT in developing a comprehensive screening instrument for risk of sexual victimization and abusiveness. At the end of the clinician's intake evaluation is now a PREA Risk Screening section. This section accounts for all required elements of this standard and contains a scoring mechanism which indicates sexual risk and triggers notification of the Residential Supervisor upon the affirmative response to certain questions. This is specified for the Risk of Victimization section as well as the Risk of Aggression section. APT PREA Policy and training materials were revised to include the screening instrument and the procedure for completing it and appropriate housing/other determinations.

   During the second onsite visit, implementation of the revised screening had not yet been done. It wasn't until 8/12/17 that the new risk screening form was provided to auditors. It was put into practice after that. Auditors requested completed risk screenings and received them. On 9/5/17, 3 completed screenings were provided with completion dates of 8/22/17 and 8/31/17. Thus, the risk screening was implemented less than one month prior the deadline of the completion date, not constituting enough time to demonstrate institutionalization. Many discussions, emails, and phone calls with the facility leadership during both onsite visits and throughout the corrective action period emphasized the requirement and importance of demonstrating institutionalization; urging that corrective action documentation be provided enough in advance to do so.

   Furthermore, documentation of reassessments within 30 days were not and could not be provided because the risk screening had not been in place longer than 30 days.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Intake screening and other forms

Interviews, Document and Site Review:

APT PREA policy addresses all the provisions of this standard but without any specific procedure or monitoring system. There was no documentation to show that APT uses screening information to decide housing, bed or program assignments. Some of the required screening information is obtained at intake (telephone) and others are obtained in the initial assessment by a Clinician at a later date and on a different form which is part of the residents' electronic health records. Also, there is no documentation that shows how individualized determination are made to

ensure the safety of each resident. Once a screening instrument as outlined in 115.241 is implemented, APT will be able to utilize this information more effectively.

APT did not admit any transgender or intersex resident in the last 12 month. Policy does indicate that transgender and intersex residents' own views with respect to safety shall be given serious consideration and will be given the opportunity to shower separately from other residents and this was echoed in interviews with the PREA Coordinator and leadership. It was clear that this consideration was of the utmost importance and is a practice at the facility.

Policy indicates that lesbian, gay, bisexual, transgender, intersex residents will not be placed in dedicated housing solely on the basis of such identification, which was also evident in interviews and by observation during the site review.

Corrective Action:

1. Use information obtained from the newly developed screening instrument, pursuant to corrective action in 115.241 to inform bed, housing, program, and work assignments. Provide documentation to show how the screening information is used. The goal is to keep those at high risk of being abused separate from those at high risk for being abusive.

Update on Corrective Action:

1. A PREA screening instrument was implemented as part of the clinician's intake evaluation as well as a Risk Plan form and process by which to inform decision making (housing, bed, program, work assignments). If elevated risk is present as indicated on the PREA screening instrument, this triggers a PREA Risk Plan to be created. The Risk Plan denotes whether the risk is due to victimization or aggressive factors. The Plan then prompts staff and documents that the resident has been informed of PREA information and reporting mechanisms. At the bottom of the form is the Housing Plan, which documents where the resident is being housed, the justification for the housing, and the resident's perception of safety regarding the Housing Plan. Only three Risk Plans were provided for auditor review since the PREA screening was implemented only in late August. This process in place now for keeping those at high risk of being sexually abused separate from those at high risk for being sexually abusive, yet it has not been in practice long enough to be institutionalized and therefore its effectiveness cannot be verified by auditors. Three risk plans to review do not give enough insight into whether proper and sufficient information is contained in the Housing Plan and then verify that the information did, in fact, keep the resident safe.

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)

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Resident handbook
- PREA posters

Interviews, Document and Site Review:
APT PREA Policy addresses each provision of this standard and cites the ways in which compliance is met.

Review of PREA policy, staff interviews, resident handbook and PREA posters available in all resident areas confirmed the provision of multiple internal ways for residents to privately report sexual abuse – to any staff member or Supervisor, PREA Coordinator with telephone number, President/CEO with telephone number and overnight/after-hours Supervisor with telephone number.

Review of documentation and policy confirmed 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 reports to agency officials – State of Connecticut Department of Mental Health and Addiction Services with telephone number, Connecticut Department of Corrections with telephone number and Court Support Services Division with telephone number.

APT policy states that the resident can remain anonymous, but the PREA poster and resident handbook does not mention allowing the resident to remain anonymous upon request. Minor recommendation is to include in resident handbook and poster that residents can report anonymously and that staff will accept anonymous reports. Staff interviews confirmed that information about remaining anonymous is given to the residents when they discuss PREA.

APT does provide a method for staff to privately report sexual abuse and harassment of residents by immediately notifying any Supervisor, On-call Supervisor, PREA Coordinator or President/CEO. This was consistently reported through random staff interviews and discussion with leadership and others.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- Residential Client Handbook
- Grievance Form
- Policy: Grievance Procedure

Interviews, Document, and Site Review:
APT does have administrative procedures for dealing with resident sexual abuse grievances and the PREA Policy addresses each provision of this standard and outlines their method of compliance. The PREA Policy states that APT "does not expect a resident to attempt to resolve any grievance with staff pertaining to sexual abuse." It also states that APT "typically applies a 30-day limit for reporting grievances. The time frame shall not apply for residents who are reporting a grievance involving sexual abuse."

Furthermore, the PREA Policy asserts that residents submit grievances directly to the Foundation Administrative Offices, therefore, not going through and facility staff member and that APT will not assign review of the grievance to any staff member involved in the grievance. The policy complies with all elements and response times in provision (d) and, in practice, would likely exceeds response times. In terms of emergency grievances, policy states the agency will provide an initial response within 48 hours and final decision with 5 calendar days.

Auditors were also provided with the Grievance Procedure Policy, which states that the grievance procedures are overseen the Director of Clinical Operations (i.e. PREA Coordinator). This policy exceeds response times outlined in this standard by stating, "The Director of Clinical Operations will return a call within 48 hours and issue a final determination within 5 working days." This policy neither includes nor precludes the requirements of this standard. It is recommended that both the Grievance Policy and the PREA Policy regarding grievances be congruent and include uniform information. As stated in the Grievance Policy and as learned onsite, residents can submit a grievance to the State of Connecticut and there is a locked grievance box onsite to submit grievances. Auditors were told that this grievance box is checked by the state. However, it was unclear how or whether the two grievance systems intersect at all or whether residents have information that makes clear the difference between the two. Despite several attempts, auditors were not clear either.

APT reported there have been no sexual abuse grievances during the review period and no emergency sexual abuse grievances. Policy states that residents will not be disciplined for submitting a sexual abuse grievance unless the agency demonstrates that the grievance was filed in bad faith. During the review period, there were no residents that were disciplined for filing a sexual abuse grievance.

Since there were no reports of sexual abuse grievances, auditors had no records to review for verification of this process. During resident and staff interviews, there was no report of sexual abuse grievances that were submitted. It is important that residents are informed of their rights and ability to submit a sexual abuse grievance and in turn the agency's response. Therefore, auditors reviewed the Residential Client Handbook which addresses grievances on page 25. This section of the handbook gives an overview of grievances and then refers the resident to the Grievance Policy/Procedure on the Ground Floor. The information in the handbook encourages the resident to resolve the grievance directly with the staff member or with the staff member's supervisor. If not satisfied at that point, they may fill out a Grievance Form and submit it to the RSD Director or designee for review. If not satisfied at that point, a resident may then submit it to the Administrative Offices. Thus, this information is not congruent with that in the PREA Policy and should be amended to reflect policy language and procedure.

Corrective Action:

1. Amend the grievance information in the Residential Client Handbook to reflect accurate policy and procedures regarding sexual abuse grievances. Ensure that residents have information that distinguishes the difference between the APT grievance procedure and the State of Connecticut grievance procedures; particularly, the function of the locked grievance boxes.

<u>Update on Corrective Action</u>:

1. Auditors discussed with the agency the guidance and interpretation of this standard; options being to fully implement and be able to demonstrate response according to all provisions OR be exempt by creating a scope exclusion for sexual abuse and sexual harassment grievances. If excluding such grievances, it was explained,

this scope exclusion would need to be expressed in policy as well as to residents. APT chose to amend policy language and information in the Resident Handbook to reflect the scope exclusion for sexual abuse and sexual harassment grievances. Both policy and resident material was provided to auditors as verification as well as a posting that is above each grievance box explaining this exclusion.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Residential Client Handbook
- PREA Poster

Interviews, Document and Site Review:

APT reported that they do offer residents access to outside emotional support services and the PREA Policy also addresses this. Policy state that residents will be given mailing address and phone numbers and that clinical staff will assist residents in making contact. Facility staff are charged with conveying the extent to which these communications will be monitored and/or forwarded to authorities. The PREA Policy also states, "The APT Foundation maintains a comprehensive list of supportive services provided by other agencies. Many of these resources are able to provide confidential emotional support services related to sexual abuse. In cases where a formal agreement via MOU is in place, the agency maintains files in the administrative office."

The PREA Coordinator explained that he was currently working on establishing an MOU with the Center for Women and Families; a local community-based organization. He reported that they are receptive to offering crisis intervention and advocacy services to APT and knew of PREA. He plans to add information about the Center for Women and Families to the Client Handbook and training.

The PREA poster posted around the facility lists methods of report including to the State of Connecticut Department of Mental Health and Addiction Services at the following number: (860) 418-6933. It does not include a mailing address. Auditors called the listed phone number and left a message, but never could get a return phone call.

Corrective Action:

1. APT shall provide mailing addresses along with the phone number of emotional support.
2. Provide some documentation (correspondence, email, etc) from the Mental Health and Addiction Services stating that they can and will provide these services and how this shall be accessed.

Update on Corrective Action:

1. APT established an MOU with a community-based organization (Women and Families Center) that provides crisis counselling and advocacy for victims of sexual abuse. This is a better option for APT than State of Connecticut Department of Mental Health and Addiction Services as the community-based organization is more targeted for victim advocacy and is more responsive to these needs. The MOU was provided for auditor review and contains detailed information about the responsibilities of both entities. This contact information is included on the PREA posters and the handbook. Mailing address and telephone numbers are included.

Standard 115.254 Third-Party Reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- PREA poster

Interviews, Document and Site Review:

APT PREA Policy provides that third party reporting mechanisms, including phone numbers for both the PREA Administrator and after-hours supervisory staff, are listed on the agency website.

This was verified by the auditors. The agency website home page contains a zero tolerance statement with a link for further information. Upon following that link, a section about PREA is found, which includes the following contact information for third parties:

- *The PREA Administrator at (203) 781-4600 during regular business hours (8:30 – 4:30 M-F)*
- *The APT Foundation after-hours Supervisor at (203) 584-9447*

Reporting information is posted around the facility and in the visitation area includes: methods of report; internal and external as well as phone numbers for third parties to contact. In addition, during interviews, residents were aware that a report could be made by third parties.

Corrective Action:

None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT's PREA Policy addresses each provision of this standard. In regard to provision (b), policy states that information regarding sexual abuse incidents shall be maintained by staff "as confidentially as possible."

The policy also asserts that the agency does not serve residents under the age of 18, which was confirmed in interviews with leadership. Thus, provision (d) is not applicable.

Interviews with staff exuded the fact that resident safety was first priority and all said they report sexual abuse and sexual harassment as well as all other reportable incidents immediately. It was also clear that all allegations would be immediately forwarded to the PREA Coordinator; the designated investigator.

Although PREA Policy cites provision (c), it was not clear during interviews that medical and mental health staff disclose to residents their limitations to confidentiality and duty to report, upon initiation of services, which is required by this standard.

Corrective Action:

1. Medical and mental health staff shall disclose to residents their limitations of confidentiality and duty to report, upon initiation of services. This can be done verbally and/or can be accomplished with written material or postings provided to residents.

<u>Update on Corrective Action</u>:

1. The medical intake documentation was revised to include information on limits of confidentiality and duty to report sexual abuse that occurs in custody. This information is now given to each resident. Auditors were provided this information to review and deemed that it contains the required information. After the second onsite visit, when additional phone and web interviews were conducted on 9/18/17, a medical staff member was interviewed and was able to articulate this practice.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
APT's PREA Policy cites this standard and all staff interviewed reported they would take immediate action if they learned a resident was subject to a substantial risk of imminent sexual abuse.

Interviews with staff including facility and agency leadership as well as random staff indicated that sexual safety for residents is a high priority. Staff were able to articulate options available that could be implemented to ensure resident safety.

There were no instances of a resident being at risk of imminent sexual abuse during the reporting period.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
The APT PREA Policy addresses each provision of this standard, though, they reported the RSD has never received an allegation that occurred at another confinement facility. Thus, notification to another confinement facility has not been warranted. In addition, APT has never received such notifications from another confinement facility that sexual abuse occurred at the RSD. However, during interviews with the PREA Coordinator, Facility Head, and Agency Head, it was articulated that receiving such a notification would result in initiation of an investigation.

Having not occurred, there was no documentation for auditors to review for verification.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

The APT PREA Policy addresses each provision of this standard, although for provision (b) it states, "The APT Foundation does not employ security staff at APT Residential Services. The facility is staffed by Patient Care Associates, Clinicians, and Nursing Staff (first and second shifts only)."

The Pre-Audit Questionnaire indicated there was one allegation of sexual abuse during the review period and in that instance, the alleged victim and abuser were separated. This allegation was not reported within a time period that allowed for the collection of evidence. As indicated in policy, all staff at RSD are non-security staff members and all expected to: preserve and protect the crime scene, request the alleged victim not destroy evidence, and ensure the alleged abuser does not destroy evidence. Though, interviews with staff evidenced that generally staff did not adequately articulate first responder duties pursuant to this standard.

Corrective Action:

1. Ensure staff's ability to articulate first responder duties. With enhancement of the training pursuant to 115.231, APT should be better equipped to accomplish this.

<u>Update on Corrective Action:</u>

1. Upon review of the revised training material, it was noted that the first responder duties were more clearly delineated. As further elaborated in Standard 115.231, the PREA Coordinator delivered staff training using the revised training material and provided this documentation. A posting of the Coordinated Response is also posted in the staff break room, which was provided for auditor review. Additional interviews that were conducted 9/18/17 with random staff via phone and web confirmed understanding of the first responder duties and staff were able to articulate the procedure. Specifically, staff were better able to convey the preservation and protection of the scene and to protect potential evidence on the alleged abuser and victim's person.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT Residential Services has a Coordinated Response that is outlined in their PREA Policy. It states the following:

The APT Foundation follows a team response to any emergency situation that presents at APT Residential Services. Any person can initiate the response following a suspected emergency. The initial staff person is charged with controlling the emergency while alerting other staff persons that assistance is needed. The initial staff person shall remain in position until a supervisory staff person can take control of the emergency situation. Other staff persons activated shall:

(1) Assist the initiating staff person in protecting and separating the alleged victim and aggressor;
(2) Assist the initiating staff person in preserving the scene and evidence, as indicated;
(3) Removing other residents from the vicinity where the emergency occurred;
(4) Contacting a supervisor to report the emergency situation;
(5) Contacting 911 and wait for emergency personnel to arrive on the scene and to direct to the emergency location;
(6) Contacting the Program Director to advise of the emergency situation;
(7) The Program Director will contact APT administration with any known details;
(8) The Program Director or Clinical Supervisor will contact the resident's referral source;
(9) The Program Director; APT Administration; and other professional staff will be utilized to coordinate support services for the victim;
(10) APT Administration will initiate investigation of incident, in collaboration with other external entities, as indicated;
(11) All other investigative policies are followed post-investigation.

The Coordinated Response is detailed, but could be strengthened by incorporating sexual abuse specific details such as following first responder duties alluded to in 115.264 and transportation to the hospital for forensic exam if warranted and within the applicable time frame.

Corrective Action:

1. Enhance the Coordinated Response by incorporating sexual abuse specific details such as following first responder duties alluded to in 115.264 and transportation to the hospital for forensic exam if warranted and within the applicable time frame.

<u>Update on Corrective Action</u>:

1. The PREA Coordinator enhanced APT's Coordinated Response and included this in the revised PREA Policy language; section 15.265 Coordinated Staff Response to Sexual Assault in Facility. This was provided for auditor review, which confirmed sufficient detail to coordinate response among first responders, medical and mental health, investigators, and leadership. Enhanced training material also included an emphasis on this new policy language and procedure. Additional staff interviews conducted 9/18/17 indicated staff awareness of the coordinated response. Staff affirmed delivery of the revised training and coordinated response. The PREA Incident Reporting Form documents the following: "Was the Coordinated Response Plan followed?"

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
APT does not participate in collective bargaining. APT PREA Policy states this and it was confirmed through interviews with the Agency Head and PREA Coordinator.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
APT PREA Policy does not address each provision of this standard and could be strengthened by better outlining how APT will ensure the monitoring of retaliation for residents and staff who report or cooperate with an investigation of sexual abuse or sexual harassment. This standard has a policy requirement that mandates an agency "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."

APT reported no incidents of retaliation during the review period. While there were no reports of retaliation and resident interviews concurred, it was apparent that there is currently not a formal or institutionalized method of monitoring for retaliation. Interviews with the PREA Coordinator and other facility staff indicated this to be true. Thus, auditors were not provided with a method of documenting or tracking retaliation monitoring. The PREA Coordinator asserted that retaliation is not tolerated and that "people can and have always been able to complain without retaliation."

Corrective Action:

1. APT shall enhance policy regarding retaliation monitoring in order to meet the policy requirement of this standard.
2. APT 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. For at least 90 days following a report of sexual abuse, APT 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 to monitor should include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff; monitoring beyond 90 days if the initial monitoring indicates a continuing need. In the case of residents, such monitoring shall also include periodic status checks. 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. The obligation to monitor shall terminate if the allegation is unfounded.

Update on Corrective Action:

1. The PREA policy was revised to include all the provisions of this standard as well as procedures for monitoring retaliation to include a week-by-week retaliation monitoring log. This policy and documentation was provided for auditor review in August 2017. Furthermore, staff training was enhanced to include an emphasis on monitoring retaliation and disciplinary sanctions for engaging in retaliation. Auditors reviewed the training material, as further elaborated in Standard 115.31.
2. Through the corrective action period, there were no reports of sexual abuse or sexual harassment, therefore, no retaliation monitoring was warranted. Nonetheless, APT was required to establish a practice for doing so, in the event a report was received. Specific procedures were outlined in the PREA Policy and included a Retaliation Log attachment to document week-by-week monitoring. This log prompts the documentation of: Disciplinary Reports, Program changes, Program Sanctions, Negative Performance Review/Progress Reports, and Client Safety Report/Other Concerns Reported. There was no such completed documentation for auditors to review, to assess this in practice, since no monitoring was warranted.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT PREA Policy cites each provision of this standard.

APT reports that all investigations it conducts into allegations of sexual abuse and sexual harassment are done so promptly, thoroughly, and objectively including third-party and anonymous allegations. APT also reports that substantiated allegations are referred for prosecution, though, during the review period there were no substantiated allegations and thus, none were referred for prosecution.

There was 1 allegation reported during the review period and it was reported as sexual harassment. Auditors did not receive documentation of this investigation in order to assess its thoroughness and promptness and, therefore, could not provide complete assessment of this standard.

Bob Freeman, the PREA Coordinator is also the designated investigator and provided auditors with an NIC certificate of specialized training pursuant to 115.234. See 115.234 for additional comments regarding this training.

Auditors interviewed the PREA Coordinator regarding investigative processes. Some of the process was articulated while the gathering of direct and circumstantial evidence pursuant provision (c) was lacking detail. Auditors requested policy specific to investigations, but were not provided. Overall, the investigative process seemed unstructured and not formalized. While there is policy language congruent to this standard, practice was not. Admittedly, APT reported very few allegations of sexual abuse or sexual harassment. Nevertheless, discussions with the PREA Coordinator, Facility Head, and others indicated inconsistency and a lack of structure that did not allow auditors to feel confident that investigations would be conducted in accordance with these provisions.

Corrective Action:

1. Provide auditors with investigative documents for the allegation of sexual harassment and any other investigations during the corrective action period.

<u>Update on Corrective Action</u>:

1. APT provided investigative documents for the sexual harassment allegation, which was reviewed by auditors and discussed with the facility. Since the incident occurred prior to having institutionalized an investigative protocol, documentation was incomplete in terms of including information on all interviews conducted, all sources of evidence used and obtained to make investigative findings, and a case disposition. It was stated that the incident was unfounded, though, documentation provided did not seem to support this finding since the disposition of "unfounded" would indicate that APT was able to prove that the incident did not happen. From review of the documentation provided, unsubstantiated appeared to be more justified. Nevertheless, corrective actions pursuant to this audit now gives the foundation and guidance for a formalized and uniform administrative investigative process.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT PREA Policy contains language that echoes this standard and through interviews with the PREA Coordinator (the designated investigator), it was articulated that the standard "preponderance of evidence" was used to determine whether allegations of sexual abuse are substantiated. It is necessary, however, to make clear their determination of substantiated, unsubstantiated, or unfounded for each investigation of sexual abuse and sexual harassment. While auditors were informed that the 1 investigation of sexual harassment was determined to be unfounded, auditors were not provided documentation to support this.

Corrective Action:

1. APT shall ensure that it makes clear a case disposition for every allegation of sexual abuse and sexual harassment.

<u>Update on Corrective Action</u>:

1. APT has now revised the sexual abuse incident review form to document the disposition of a case. Item #10 on the form indicates the "PREA Incident Classification" and checkboxes delineate whether it is substantiated, unsubstantiated, or unfounded.

   Auditors were provided investigative documents for the sexual harassment allegation, which was reviewed by auditors and discussed with the facility. Since the incident occurred prior to having institutionalized an investigative protocol, documentation was incomplete in terms of including information on all interviews conducted, all sources of evidence used and obtained to make investigative findings, and a case disposition. It was stated that the incident was unfounded, though, documentation provided did not seem to support this finding since the disposition of "unfounded" would indicate that APT was able to prove that the incident did not happen. From review of the documentation provided, unsubstantiated appeared to be more justified. Nevertheless, corrective actions pursuant to this audit now gives the foundation and guidance for a formalized and uniform administrative investigative process.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT PREA Policy does not address each provision of this standard. While this standard does not contain a policy requirement, an agency must demonstrate that each provision is met in practice. APT PREA Policy states the following:

(a)-1 All complaints at the facility filed by clients are responded to either verbally or in writing. This includes PREA complaints and will include whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

(a)-2 The facility completed 1 investigation during the last 12 months.

(a)-3 The facility reported the findings of the investigation as indicated above, which was unfounded.

(b)-1 If an investigation is completed by an outside agency, the APT Foundation will request findings of the investigation in order to fulfill notification of the outcome of the investigation to the client.

(b)-2 There were no investigations completed by outside agencies during the past 12 months.

(b)-3 There were no investigations completed by outside agencies during the past 12 months

(c)-1 There have been no complaints of staff to client complaints.

(c)-2 N/A

(d)-1 There was one unfounded complaint of sexual abuse or sexual harassment at the facility. There were no known charges generated from this investigated report.

(e)-1 The APT Foundation's grievance policies, including PREA, require written response to the findings of any grievance filed.

(e)-2 0

(e)-3 0

Interviews with the PREA Coordinator indicated that it is the practice to notify residents of the outcome of any investigation; related to sexual abuse or not. Auditors were informed that the client involved in the investigation of sexual harassment was notified. Auditors were not provided with this documentation, though, this standard requires the notification of only sexual abuse investigations. (Notification of sexual harassment investigations is also recommended, however.)

A facility should have a formalized method of informing residents in accordance to this standard. Though APT reported no allegations of sexual abuse during the review period, it is recommended that policy further outline how the agency will comply with each provision of this standard, who is charged with this responsibility, and how it shall be documented. In accordance to provisions (c)-(f), 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. 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. APT's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

In addition, as stated for 115.211, ancillary information (dynamic data; i.e. the number of outside investigations during the past 12 months) should be omitted from policy since that data will change over time.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
APT PREA Policy addresses this standard. It states that an employee suspected to be involved in sexual abuse or sexual harassment with a resident "will be immediately suspended until the investigation has been completed. Based on the outcome of the investigation, the staff person may receive disciplinary sanctions up to and including termination…"

During the review period, there were no allegations of staff sexual abuse or sexual harassment. Policy language asserts that discipline will be commensurate with the severity of the findings, employee's work history, prior disciplinary sanctions, etc. Policy also states that, when necessary, law enforcement and/or licensing bodies will be notified.

Interviews with the PREA Coordinator and Facility Head corroborated policy language as practice, though it has been unwarranted during this review period. Auditors were not alerted to allegations of staff sexual abuse or sexual harassment during interviews with residents and staff.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
APT PREA Policy cites the provisions of this standard, which was also echoed in interviews with the PREA Coordinator and leadership. During this review period, there were no contractors or volunteers that were suspected to have engaged in sexual abuse or sexual harassment with residents. In fact, APT does not generally utilize contractors or volunteers. Therefore, there were no records to review for verification. See additional comments in 115.232.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:
APT PREA Policy addresses each provision of this standard, states that residents are subject to a formal discipline process, and that, "A resident in these cases will typically be referred back their referral source and/or discharged from the program with a referral to another program for continued services."

Pursuant to provision (d), the policy states that APT does not offer services to correct underlying motivations for abuse. Rather, they would refer the resident to another provider for those services.

The Facility Head explained that there is a formal process for issuing resident discipline. Auditors were not provided

with a policy outlining this process, but he asserted that Patient Care Associates do not issue discipline. It is documented on a Staff Event form and Incident Report and forwarded to a supervisor and then possibly to him as the Facility Head.

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Staff Interviews

Interviews, Document and Site Review:
APT PREA Policy cites each provision of this standard, but does not elucidate the specific procedures to follow for compliance with this standard.

The policy does states that victims shall receive timely and unimpeded access to emergency medical treatment, crisis intervention services, emergency contraception information, prophylaxis for STI and without financial cost regardless of whether the victim names the abuser or cooperated with any investigation. However, the policy does not indicate who will provide this information and staff interviews did not clarify this.

Staff interviews confirmed that when qualified medical or mental health staff are not available, victims are immediately protected/separated from abuser and supervisory staff informed (per policy).

Corrective Action:
None.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT PREA Policy only cites provision (a) of this standard – facility shall offer medical and MH evaluation/treatment as appropriate to victims of sexual abuse.

Staff interviews confirmed that Mental Health staff will provide follow-up services and refer for medical care or other services when indicated. Mental Health staff interviews also confirmed that upon release from the residential facility, victims of sexual abuse are referred for continued care and that this information is documented in the treatment/after care plan. There was no documentation to review since no referrals for follow up care upon discharge was made in the last 12 months.

Medical staff is usually not physically present in the residential facility at all times, but nursing staff is available all the time. Since victims of sexual abuse with vaginal penetration would be referred to the hospital for forensic examination/evidence collection, the initial pregnancy test and STI tests would be done in the hospital. It was not clear how follow-up pregnancy tests or STI tests are performed since the initial pregnancy test in the hospital may be negative and subsequent tests positive for pregnancy.

Mental Health and Nursing staff interviewed were not able to explain APT's procedure/policy on how victims who become pregnant from sexual assault would be given comprehensive information about and timely access to all lawful pregnancy related medical services. Staff did indicate that it would make good sense to give this information to resident, but they have not had any pregnancy resulting from sexual abuse of a resident.

Corrective Action:

1. APT should include all provisions of this standard an along with specific procedures of how, when who will perform these functions. This important policy is incomplete and quite weak. Staff needs to understand the important functions required to comply with this standard and community standards of care.

<u>Update on Corrective Action</u>:

1. Auditors did not receive information or documentation establishing policy or practice to ensure the completion of follow up care, particularly relating to subsequent STI and pregnancy testing for residents as a result of sexual abuse occurring at the residential facility.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT PREA Policy cites each provision of this standard, with the exception of provision (d)(5), which states that a sexual abuse incident review shall "assess whether monitoring technology should be deployed or augmented to supplement supervision by staff."

APT reported no allegations of sexual abuse during the review period and, thus, no sexual abuse incident reviews were warranted under this standard. There was one allegation of sexual harassment, which was determined to be unfounded.

Admittedly, in interviews with the PREA Coordinator and Facility Head, APT has not yet institutionalized this practice. In order for this to occur, APT should specify a method of documenting and formalizing this practice. It is recommended that APT create a form that accounts for all the requirements of this standard.

Corrective Action:

1. Formalize sexual abuse incidents reviews by documenting the process. Ensure at a minimum, that a sexual abuse incident reviews do the following:
   (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 compliance manager.

<u>Update on Corrective Action:</u>

1. The PREA Coordinator developed a PREA Incident Review form, which was provided for auditor review. This form was sufficient in outlining the review process by citing all required elements of provision (d). It also includes the date of the incident, date of review, review team members, status update for victim including support and medical services, additional supports for the victim if recommended by the team, signature of the review chair, and a reminder at the bottom of the form that the victim must be notified of the outcome within 30 days of the incident. There were reviews warranted during the corrective action period and, thus, no completed incident reviews for auditors to review. The form and policy establish procedure with which to follow in the future.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT PREA Policy cites each provision of this standard. Provision (e) is not applicable since APT does not contract with private facilities for the confinement of residents. Provision (f) is also not applicable as there has been no request for data from the Department of Justice.

While policy language addresses this standard, auditors were provided with data or a method to track sexual abuse or sexual harassment data. The PREA Coordinator explained that he obtains data by a manual search of documents; incident reports and grievances. He plans to implement a better data system in order to analyze and detect trends, etc. The Agency Head reported that there were no sexual abuse reports, there were no trends to analyze. She also explained that the PREA Coordinator is charged with this responsibility and receives incident reports on an ongoing basis.

Without a system for the collection and maintenance of data, auditors could not review and be confident in the uniform collection of data using a standardized set of definitions and incident-based data from sexual abuse incident reviews and investigative files, as required by this standard. Auditors were not provided with Surveys of Sexual Victimization (SSV) to review.

Corrective Action:

1. APT shall collect uniform data for every allegation of sexual abuse and sexual harassment using a standardized set of definitions. At a minimum, it shall include data necessary to answer all questions from the most recent version of the SSV.
2. Data shall be aggregated at least annually and should be obtained from all incident-based documents such as reports, investigative files, and sexual abuse incident reviews. It is suggested that a spreadsheet or database be utilized to record and maintain sexual abuse and sexual harassment data; resident-on-resident sexual abuse, resident-on-resident sexual harassment, staff-on-resident sexual abuse, staff-on-resident sexual harassment, and the dispositions of each.

<u>Update on Corrective Action:</u>

1. APT asserts that uniform data elements will be collected on the PREA Incident form. The PREA Incident form was provided for review. This form also documents many other aspects of the allegation, parties involved, services, notifications and investigation.
2. Enhanced policy language in the PREA Policy outlines this collection of data on the PREA Incident form and

states that this data contains the necessary information to complete the Survey of Sexual Victimization (SSV). The PREA Incident form indicates the nature of an allegation; sexual harassment or sexual abuse (penetration or other physical contact), alleged perpetrator (employee, contractor, volunteer, or another resident), source of allegation.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Agency Website

Interviews, Document and Site Review:

APT PREA Policy cites each provision of this standard, though, preparing an annual report in accordance with this standard has not yet been done. Both the PREA Coordinator and the Agency Head confirmed this to be true. The Agency Head reported that she has not yet approved an annual report and that they were awaiting guidance from the auditors before doing so. Auditors noted, upon review of the agency website, information about PREA and zero tolerance, but there was no annual report available.

Corrective Action:

1. APT shall review data collected and aggregated pursuant to 115.287 in order to improve its sexual safety efforts and 1) Identify problem areas, 2) Take corrective action on an ongoing basis, and 3) Prepare an annual report of its findings and corrective actions for the facility and agency.
2. The annual report shall include a comparison of data and corrective action of the current year with that of previous years.
3. The annual report shall be approved by the Agency Head and made available through the agency website. APT may redact material when publication would present a clear and specific threat to the safety and security of the facility, but must indicate the nature of the material redacted.

<u>Update on Corrective Action:</u>

1. APT's revised PREA Policy was provided for auditor review on 8/10/17, which stated that the agency "website is currently being updated," but that it will reference the report data and a means to request this data. Upon discussion with the PREA Coordinator, auditors clarified that since the agency has a website, it must publish this information on it, in order to be compliant with this standard. Prior to the completion of the corrective action period, the APT website was updated to include a plethora of information about PREA, zero tolerance policy, reporting, data (in the form of the SSV) for two years, and additional resources.
2. The agency website has hyperlinks to "2016 Report: and 2017 Report," however, clicking on them produces

the Surveys of Sexual Victimization for those years and not an annual PREA report, which identifies problem areas and corrective action, and is approved by the Agency Head. No annual PREA Report was provided to auditors or is available on the agency website. Many discussions and communications were had with the agency clarifying the requirements of the annual report and offering to provide examples.

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.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document and Site Review:

APT PREA Policy cites each provision of this standard. Since data is not yet being collected and aggregated pursuant to 115.287, auditors were not able to verify practice that data is securely retained. Auditors were able to verify that data is not yet made publicly available through the agency website. Policy states that data will be maintained for at least 10 years.

Corrective Action:

1. APT shall ensure that data is securely retained and that it is made publicly available through the agency website at least annually.
2. Before making data publicly available, all personal identifiers shall be removed.

Update on Corrective Action:

1. APT has now established a means to collect uniform sexual abuse data. To date, there have been no reports of sexual abuse or sexual harassment, but systems have been put in place to collect and aggregate said data and policy asserts that requirements of this standard. The information and data that has been published on the website does not contain personal identifiers, which was verified by auditors.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about

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

Talia Huff _ 12/27/17

Auditor Signature Date